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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

6 July 2002

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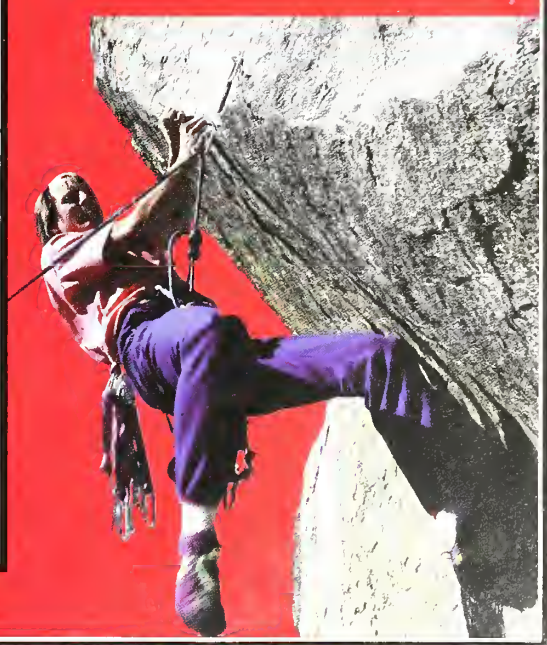
Johnson & Johnson MSD HP10 9UF. Legal status: GSL

Ex-presidents' concern over modernisation

Ulster funds pharmacy security steps

Pharmacy2U gives online PMR access

What's the risk? Making premises safe

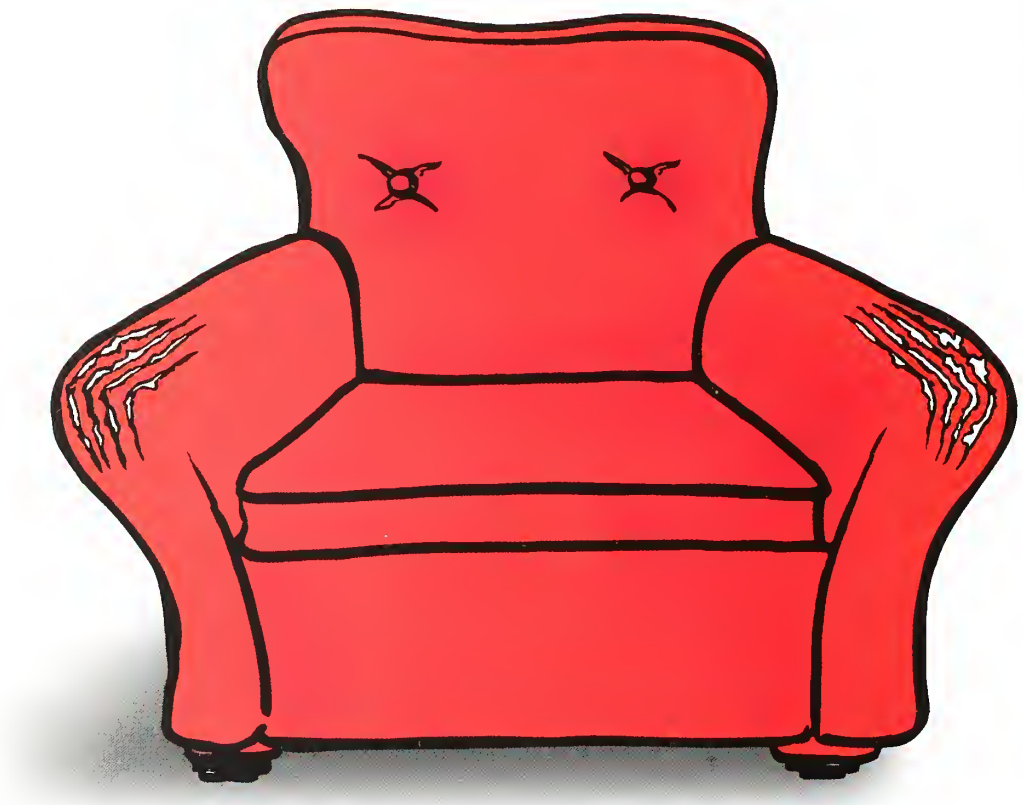


Eumovate Eczema & Dermatitis Cream Product Information.
Presentation: Cream containing clobetasone butyrate 0.05% w/w **Uses:** Short-term treatment and control of patches of eczema and dermatitis including atopic eczema and primary irritant and allergic dermatitis **Dosage and administration:** Adults and children, aged 12 years and over Apply sparingly to the affected area twice a day for up to 7 days If the condition improves within 7 days stop treatment If condition does not improve in the first 7 days or becomes worse, or if after 7 days treatment an improvement is seen but further treatment is required, the patient should be advised to consult a doctor To be used in children under 12 years only on the advice of a doctor **Contraindications:** Known hypersensitivity Broken skin or skin lesions caused by infection with viruses (e.g. herpes simplex, chicken pox), fungi (e.g. candidiasis, tinea) or bacteria (e.g. impetigo) Acne vulgaris **Precautions:** Absorption can be increased by occlusion so treatment is limited to no more than 7 days continuous treatment without occlusion Treatment should not be initiated at the same site for a third time without medical advice Only to be used for the treatment of eczema or dermatitis as other conditions may be masked or exacerbated Should not be used on the face, groins, genitals or between the toes. Medical advice should be sought in seborrhoeic eczema. Consumers should be warned against letting the cream get into the eye, as topical steroids can cause glaucoma Do not use with other topical corticosteroids or in the treatment of psoriasis. **Pregnancy and lactation:** Use only on the advice of a doctor **Side effects:** Hypersensitivity Exacerbation of symptoms **Legal category:** P. **Product licence number:** 10949/0346 **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS. **Further information available on request from:** Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Wallis House, Great West Road, Brentford, Middlesex, TW8 9BD **Package quantity and RSP:** 15 g tube – £5.49 **Date of preparation:** August 2001 Eumovate is a registered trademark of the GlaxoSmithKline Group of Companies

© GlaxoSmithKline UK Limited, 2001.

References:
1 Munro DD, Wilson L Br Med J 1975, **3** 626-8
2 Parneix-Spake A, Goustas P, Green R J Dermatol Treat [In press]

SKIN RAGE?



Before it gets to this, get to them

Skin Flare-Up due to eczema and dermatitis, characterised by itchy, red, dry and inflamed skin, can be extremely aggravating. Eumovate Eczema & Dermatitis Cream, available without prescription, acts early and helps break the Itch-Scratch Cycle, before it gets out of control.

No other over-the-counter medicine clears Skin Flare-Up more effectively than Eumovate Eczema & Dermatitis Cream.[1,2]

for Skin Flare-Up

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www.dotpharmacy.com

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The New Weekly for Pharmacy

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PPA ABC CMP United Business Media

This week

Regulars

Pharmacy today

Features

Ex-presidents challenge plans

Eleven past presidents of the Royal Pharmaceutical Society have joined together to challenge the Society's plans for modernisation.

In the same week, the National Pharmaceutical Association has claimed that the process is proceeding in too tight a time frame. And the Young Pharmacists' Group is joining the call for individual pharmacists to make the Society more aware of their views.

The past presidents have signed a joint letter this week saying it is "fundamentally wrong" that the Society should compare itself to other professions' regulatory bodies in taking forward the modernisation plans. The Council's proposals will have "the inevitable consequence that the professional representative function is subjugated to the regulatory role", says the letter.

"A representative body must be governed by the people it represents – how else can it be representative?" it adds.

The past presidents appreciate the Government's view that greater lay involvement is needed. "But it is fundamentally wrong, as the Council's consultations do, to compare the Society only with other health regulators such as the General Medical Council.

Sharpe: Council is "irresponsible and acting against the best interest of the profession"

"We would only support a structure that will ensure that the professional representative role of the Society continues to be performed by a body with similarly professional/lay composition to the present, with the lay member involvement in the regulatory functions required by the Government."

One of the signatories, David Sharpe, said the letter "demonstrates vividly the strength of feeling about the Council's proposals". He accused the Council of being "irresponsible and acting against the best interest of the profession".

Mr Sharpe commented: "What we are asking for is the Council to listen more to the widespread opposition ...not take decisions that appear to be unilateral."

Meanwhile, the NPA Board "is concerned about the short time scale attached" to the Society's consultation paper on the possible responsibilities and composition of a future Council. "While fully recognising that the timetable for regulatory reform is tight, the Board feels that insufficient time is being given to the Society's consultation process given its importance to the profession," it said on Tuesday.

The Board was also concerned that the proposed model will be unworkable. It added that the Society appears not to have explored any alternative models.

The YPG says it has received a positive response to its proposals. Noel Wicks said he hoped they had helped clarify an issue "which up until recently the membership had felt bamboozled by".

The YPG is joining the call made by the past presidents that all pharmacists should respond to the Society. The past presidents asked that pharmacists send a simple letter to the Society saying that they support the principles in the alternative proposals put forward by the YPG.

Modernisation will up fees

Pharmacists should expect to see an increase in the Royal Pharmaceutical Society's annual retention fee due to the work involved in the modernisation programme.

President Marshall Davies said that he thought the retention fee would be affected by the modernisation agenda. "It's unlikely to be less," he said, although he could not confirm how much the fee would increase.

The RPSGB is keen to encourage all pharmacists to take an interest in the modernisation programme, as it will have far-reaching effects on how the profession is regulated and represented in the future. "Any feedback from pharmacists would be welcome," said Philip Green, director of professional development and deputy secretary of the Society. Mr Davies confirmed that the Council would consider all of the issues raised in the modernisation steering group's discussion papers.

"I warmly welcome all contributions to help inform this debate," he added. "I have seen the YPG's document in the pharmacy press (*C&D June 29, p5*) and hope that they will also submit it to the Society as a formal response to our consultation process.

There is only a short time scale for pharmacists to respond to the Council's proposals but Anne Lewis, secretary and registrar, said the time frame was being imposed by the Government's legislation agenda. The formation of the Council for the Regulation of Health Professionals, which could be in place by the autumn, meant that the Society had to show that it was "managing its affairs" with regards to regulation.

NPA

NPA opens debate on membership

The National Pharmaceutical Association has made "significant steps" towards widening its membership.

At its meeting last week, the Board decided "to give serious consideration to creating a membership category for individual pharmacists". This is in line with the sixth objective of its five-year strategic plan announced last autumn. The overriding proviso, however, would remain that the NPA is faithful to its core members, and the establishment of an individual membership category would benefit existing members, said head of practice Colette McCreedy.

"The benefits we see are that we will be supporting all those who work in or interface with the community sector," she said. "That has to be good for all our members." Having employee pharmacists and locums as members could strengthen the profession in the community, she argued. If substantial new members are attracted, as well as increasing NPA revenue for developing better and new services, it will also give the NPA an increased representational role.

The core membership will be deciding on policy, but from a representational view, the NPA is considering a forum for individual members, she added.

No time scale has been put on introducing a new category. "We now need to look at detail, costings and gauge interest," said Mrs McCreedy. But she stressed: "We are not going to be providing a forum for employment/trade union type issues because that clearly is a conflict of interest for our members."

McCreedy: an individual category would benefit existing members

Facial art: this photograph by Kyle Hamilton, a student at Stevenson College, earned her second place in the fashion category of Fujifilm Professional's Student Awards 2002. This is an annual photographic competition which this year attracted over 700 entrants, who submitted more than 2,000 images between them

SCOTLAND

Antimicrobial resistance tackled

The Scottish Executive Health Department has announced a strategy to tackle the problem of antimicrobial resistance in Scotland.

The UK Antimicrobial Resistance Strategy and Scottish Action Plan has three key elements: surveillance, prudent antimicrobial use and infection control.

Key points for pharmacists are:

- they will be expected to work with area Drug and Therapeutics Committees to review and monitor local guidelines on antibiotic prescribing
- the Scottish Prescribing Advisors Association will gather data and audit optimal prescribing in line with Standing Medical Advisory Committee (SMAC) recommendations in Scotland
- general practitioners will be expected to work with community pharmacists to implement policies and guidelines, monitor and review antibiotic prescribing.

For more information:

www.scotland.gov.uk

NORTHERN IRELAND

Contractors get funding to upgrade security

Pharmacy contractors in Northern Ireland have won Government funding to upgrade their security arrangements.

Following a spate of armed robberies in pharmacies, especially in the Belfast area, health minister Bairbre de Brún announced a funding package for community pharmacists. This will allow for the installation of safes with time-lock delays to store medicines liable to abuse.

A total of £600,000 will be made available in a joint initiative between the Northern Ireland Office, the DHSSPS, and the Northern Ireland Drugs and Alcohol Campaign Initiative.

Up to £1,000 is available to contractors who install a safe which meets specific criteria laid down by the Pharmaceutical Contractors Committee.

"The robberies have been occurring for the last 18 months with alarming regularity, and I believe this is just the tip of the iceberg. One pharmacy has been robbed three times in eight weeks," said Terry Hannawin, the PCC's chief executive.

The use of such safes as a professional requirement is currently being debated by the Pharmaceutical Society of Northern Ireland, confirmed its chief executive, Sheila Maltby.

And it is understood that this could become a statutory requirement some time in the future.

"I am confident that the new security measures put in place will go a long way to deterring the criminal element from these robberies," said Ms de Brún.

"Pharmacies provide a front line service to the local community and it is essential that patients have access, especially when they are in need of vital medication. Pharmacists and their staff who deliver this essential service must be allowed to work free from the fear of attack."

Posters highlighting the security measures will be available to pharmacies to display to customers.

- A consultation paper about protecting personal information in Health and Personal Social Services organisations was launched by Bairbre de Brún last Thursday.

It highlights the need, where possible, to obtain user consent for the use of information, particularly in situations other than the provision of direct personal care.

For more information:

www.pccni.org.uk

www.dhsspsni.gov.uk/publications

NCSO scripts

The Department of Health and the National Assembly of Wales have agreed to allow NCSO endorsements for the following items for July 2002 prescriptions: citalopram 20mg tablets and citalopram 40mg tablets.

The PM, *Woman* and pharmacy

The National Pharmaceutical Association is placing a series of adverts in a special edition of *Woman* magazine.

The one-off summer special dedicated to health will feature an exclusive interview with the Prime Minister. Mr Blair talks about his views on parenthood and family issues and it is expected there will be national media interest.

The magazine will go on sale on July 25 priced at £1.60.

Pharmacy strategy imminent for Wales

A 10-year pharmacy strategy for Wales will be published as a consultation document this month.

Jane Hutt, health and social services minister for the National Assembly, said during a debate last week that the strategy was at an "advanced stage".

"This is the first attempt to produce an integrated strategy for all branches of the profession that make up the pharmacy family. The document will focus on the pharmaceutical needs of the individual and how they can be met," she added.

For more information:

www.wales.gov.uk

Update MCQ enclosed

This week's issue contains the questionnaire for the following Pharmacy Update modules carried in June:

- Reproduction (1237)
- Oral Contraception (1238)
- Coeliac disease (1239).

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on *www.dotpharmacy.com*. Further information is available from Mary Prebble on 01732 377269. Genus Pharmaceuticals supports the MCQ and telephone marking service.

Supplementary prescribing is 'too detailed'

The National Pharmaceutical Association has said some aspects of the Government's supplementary prescribing proposals need altering.

In its response to the Medicines Control Agency's consultation letter MLX 284, the NPA said:

- the definition of supplementary prescribing is too detailed and may prove unnecessarily restrictive in practice
- all registered pharmacists should be considered eligible to apply for a prescribing role from the outset
- supplementary prescribing by nurses and pharmacists should be implemented simultaneously
- primary care pharmacists should not necessarily be considered as the most appropriate supplementary prescribers over community pharmacists
- to overcome potential problems of supplementary prescribers accessing patients' medical records the NPA suggests that the use of patient-held records be implemented. An additional benefit of this is that patient consent to a healthcare professional accessing records would be assured
- separating prescribing and dispensing responsibilities will inhibit the development of a supplementary prescribing role for community pharmacists. Insisting on this option will lead PCTs, GPs and patients to believe that combining the responsibilities is a last resort
- any argument that community pharmacists be denied the opportunity to become supplementary prescribers on safety or governance grounds is unsustainable
- the prescribing partnership must take into account the contribution made by teams of healthcare professionals rather than just individuals. This would be useful where a pharmacy has extended opening hours and several pharmacists are employed
- the way in which community pharmacists are to be accredited as supplementary prescribers could potentially be a barrier. Demonstration of competence rather than the number of days of "teaching contact time" should be the key requirement
- training for supplementary prescribers should be funded by the NHS Regional Workforce Confederations.

Pictured at the conference are, from left: Nick Lowen, trading strategy manager for GlaxoSmithKline; Joe Asghar, directorate of social health care (North); RPSGB Council member Gerald Alexander; chief pharmaceutical officer Dr Jim Smith; NPA chief executive John D'Arcy; and Umesh Patel, NPA Board member and conference chairman

POLICY

Smith urges pharmacists to collaborate more

Chief pharmacist Dr Jim Smith has urged pharmacists in the primary care sector to stop competing and start collaborating.

"We as a profession can make the system work for the benefit of all," he told over 100 delegates at the Northern Regional Pharmacy Conference in Gateshead last month. He argued that collaboration will help ensure that the huge challenges facing the profession could be overcome.

Dr Smith pointed out that by 2004, PCTs would be controlling 75 per cent of all NHS spending, including the drugs bill. He also stressed that the Government was seriously looking at public/private partnerships; community pharmacy was a perfect example of a successful PPP.

Another change will be supplementary prescribing. While there would be no outright bar to any section of the profession becoming supplementary prescribers, regulation of support staff and training would be part of the standards required for supplementary prescribing.

He acknowledged this would increase community pharmacists' costs, but said that the process should be seen as empowering the profession.

National Pharmaceutical Association chief executive, John D'Arcy, said pharmacists want to undertake new roles, but warned the profession may be reluctant to delegate existing roles.

Questiontime

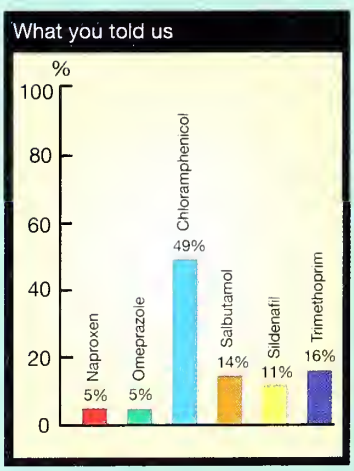
in association with UniChem

Last week we asked you: "Which Prescription Only Medicine would you most like to see available over the counter?" You replied (see right):

This week's question: What is your main concern about the Royal Pharmaceutical Society's modernisation plan?

- No concerns
- It is proceeding too quickly
- The membership does not understand the Society's reasoning
- The Society will lose its representational role
- It does more than the Government is asking
- Other proposals need to be investigated first

You can record your vote on our website: *www.dotpharmacy.com* Question Time appears on the home page. Select your answer and then click on the "vote" box. Your answer is automatically collated. You have until noon on July 9 to cast your vote. We will publish the results in *C&D*, July 13.



SURVEY

Risks of tablet crushing

Nurses are putting patients' lives at risk and themselves at risk of prosecution by crushing tablets, according to a survey in *Nursing Times* this week. It reveals that:

- 84 per cent of nursing home nurses had crushed tablets or opened capsules in the last year
- 58 per cent of nurses said that the prescriber might recommend this practice.

David Wright, a lecturer in pharmacy practice at the University of Bradford, found that crushing or opening medication takes place in over 80 per cent of nursing homes on a weekly basis.

BIGGER PACK. BIGGER PROFIT.

Zantac 75 is now available in a pharmacy-only 48 pack, so that you can offer your customers extra value while earning good profit on return for your pharmacy.

Zantac 75 is the fastest growing pharmacy-only heartburn treatment,[1] and is driving category growth,[1] offering sufferers a once daily stand against food attack. You can even recommend Zantac 75 to prevent an attack altogether.

48 TABLETS

Zantac™ 75

HEARTBURN & INDIGESTION RELIEF FOR UP TO 12 HOURS

ranitidine (as HCl)

A long-lasting force for comfort

Zantac 75 48's Product Information
Presentation: each tablet contains 75mg ranitidine. **Uses:** Symptomatic relief of heartburn, indigestion, acid indigestion and hyperacidity and prevention of heartburn, indigestion, acid indigestion and hyperacidity associated with consuming food and drink. **Dosage and Administration:** Adults and children aged 16 and over, one tablet. For prevention of heartburn and indigestion associated with food and drink, one tablet half to one hour before eating or drinking. No more than four tablets should be taken in any 24-hour period. **Contraindications:** Hypersensitivity. **Precautions:** Treatment should be restricted to maximum of 14 days continuous use at any one time. Patients should contact their doctor if their symptoms do not improve after 14 days continuous treatment. Should not be taken by the following groups of patients unless under medical supervision: patients with renal or hepatic impairment; patients under regular medical supervision or suffering from any other illness or taking medication; patients middle aged or older with new or recently changed symptoms of indigestion; patients with unintended weight loss; patients taking NSAIDs; patients with a history of porphyria; patients who are pregnant, trying to become pregnant, or breast feeding. **Side Effects:** Generally well tolerated. Rarely changes in liver function tests, hepatitis, jaundice, acute pancreatitis, leucopenia, thrombocytopenia, agranulocytosis, pancytopenia, marrow hypoplasia, aplasia, hypersensitivity reactions, bradycardia, A-V block, headaches, dizziness, confusion, depression, hallucinations, involuntary movement disorders, skin rash, vasculitis, alopecia, musculoskeletal symptoms, impotence and breast swelling/discomfort in men. See SPC for further details. **Legal Category:** P. **RSP (ex VAT):** Zantac 75 48's £9.07. **Product Licence Number:** PL 10949/0223. **Licence Holder:** Glaxo Wellcome UK Limited, Stockley Park West, Uxbridge, Middlesex, UB11 1BT. Further information available on request from Medical & Consumer Affairs, GlaxoSmithKline Consumer Healthcare, 980 Great West Road, Brentford TW8 9GS. **Date of Revision:** February 2002. Zantac 75 is a registered trademark of the GlaxoSmithKline Group of Companies. **Reference:** 1. IRI: All Outlets, 2001.

gsk GlaxoSmithKline

Scottish minister 'ignores' threat to pharmacies

Scotland's community pharmacy leaders have condemned the health minister for failing to address the problem of violence against community pharmacists and their staff.

Last week health minister Malcolm Chisholm, responding to a question from Margaret Smith MSP, said that the Scottish Executive's draft guidance on violence covered threats and intimidation towards NHS staff.

However, when Mrs Smith pointed out that this had also become a problem for pharmacists and asked if the Executive planned to change the law to include the public sector workforce, Mr Chisholm replied: "The question is not a matter for me as minister for health and community care."

Ian Johnstone, chairman of the Scottish Pharmaceutical Federation, said: "Threats and actual acts of violence are on the increase in Scotland's pharmacies. The minister's failure to address this in Parliament is not acceptable."

Mr Johnstone added: "We would like to thank Margaret Smith for raising the violence issue. We are deeply frustrated that the minister did not take the opportunity to address our growing concerns, nor appeared to understand that violence to NHS staff and contractors is not confined to hospitals and surgeries.

"It is an everyday reality for community pharmacists, particularly in areas of high drug abuse, and one which urgently requires to be addressed by the Scottish Executive."

For more information:
www.scotland.gov.uk

APBI

Medicines information plans 'are flawed'

European Commission proposals on patients' access to information about Prescription Only Medicines are flawed, says the Association of the British Pharmaceutical Industry (APBI).

Plans to broaden the definition of advertising to include promoting awareness of medicines would effectively ban such activity, the ABPI told British MEPs.

"We do not seek advertising of prescription medicines to the public. But it is in the interests of both patients and industry to ensure that the current definition of advertising is not widened, thus effectively banning the useful public health work the industry currently undertakes," said Dr Trevor Jones, ABPI director general.

In addition, the ABPI claims that the EC's proposed pilot system to allow patients access to information provided by the industry in three disease states – HIV/AIDS, diabetes and asthma – could discriminate against people with other diseases.

"The situation would be even more of an anomaly for patients with more than one condition, who can get information on one disease but not others," said Dr Jones. "The industry strongly supports the principle that anybody should be able to receive information from any source they choose."

For more information:
www.apbi.org.uk

A 28-strong delegation of Danish pharmacists and pharmacy technicians visited Mawdsley's new depot at Milton Keynes. The trip, organised in conjunction with Danish wholesaler Oripharm, is an annual event and is intended to give independent pharmacies across Denmark the chance to keep up to date with pharmacy issues in the UK. The group was greeted by Mawdsley's retail services director, John Davies (left), Pauline Panter, its Milton Keynes depot manager (right), and Debbie Evans, export manager (second right)

PRACTICE

Motivating pharmacists to bring in SOPs

What would motivate you to write standard operating procedures for dispensing and then stick to them once written?

This was one of the questions put to a meeting on Monday at the Royal Pharmaceutical Society, when representatives of the main pharmacy organisations, the multiples and the inspectorate discussed how to encourage pharmacists to have SOPs in place by January 1, 2005. These are some of the points raised:

- SOPs must be sold to pharmacists as something they want to do – the "what's in it for me" factor – rather than something to fear. SOPs shouldn't be seen as SEPs (someone else's problem)
- in practice most pharmacies already conform to standard procedures; all they need to do now is write them down. Pharmacists already explain to new staff how the pharmacy deals with prescriptions; writing this down could be the basis of the SOP on "handling prescriptions"
- one incentive is likely to be PCTs, which might not accredit pharmacies until SOPs are in place
- independents will need more help, as they do not have the same support structures as multiples
- any guidance from pharmacy organisations cannot be absolutely prescriptive. Pharmacists will need to adapt the basic requirements to suit local circumstances
- some pharmacists might prefer SOPs to be ready written, but this carries the risk that the document might be put on one side and ignored. A template could be a better alternative
- the NPA has tested and will release templates for SOPs
- there should a method of showing that a pharmacy has SOPs in place
- the CPPE is organising clinical governance workshops this autumn, which will cover SOPs. The CPPE can now offer pharmacists in England the Welsh CPPE's SWEEP package, giving guidance on writing and implementing SOPs.

The Society will consider the points raised when moving forward with its guidance *(see also p16)*.

Stake your claim in the future of independent pharmacy

Applications for shares to arrive before July 20th

(Pink Form)

Cut out and keep as a reminder!

Make sure 2nd Proxy Form arrives by July 20th

(Yellow Form)

Cut out and keep as a reminder!

All existing Numark shareholders now have the chance to increase their stake in the company to 19,200 shares. You can also apply for 'Excess' shares. Application forms for this process were sent out with your prospectus.

A key part of the Numark Conversion is the raising of capital which will allow us to put our business plan into action, and turn our shared vision for the future of Independent Pharmacy into reality.

The closing date for share applications is Saturday 20th July. Your second Proxy Voting Form must also be received by the same day.

If you have any queries, call Stephen Marks on 01827 841200 or Jonathan Cable on 020 7003 3000.

NUMARK PHARMACISTS

PUTTING YOUR HEALTH FIRST

Anti Itch
Balneum® Plus

soya oil, lauromacrogols

Balneum Plus is more than just an emollient.

That is because it contains lauromacrogols, which are proven to relieve the itch associated with eczema and dry skin conditions.

You'll find that it more than comes up to scratch.

Because scratching is for cats.

Prescribing Information – Balneum® Plus: Balneum Plus is an oily liquid for external use containing soya oil 82.95% w/w and mixed lauromacrogols 15.0% w/w. **Uses:** For the treatment of dry skin conditions such as eczema and dermatitis where severe pruritus is also experienced. **Dosage and administration:** Adults: For full bath (~100L)-20ml=1 measure. For partial bath (~5L)-2.5ml=1/8 measure. For baby's or child's bath (~25L)-5ml=1/4 measure. For very dry skin, 2-3 times the above quantities can be used. Add to bath water. Frequency and duration of application depend upon the type and severity of the condition. For adults – at least 3 times per week. For babies and infants – daily application is recommended. Balneum Plus can also be used in the shower by applying evenly without dilution and rinsing away excess by showering. **Contra-indications, warnings etc:** Contra-indicated in patients hypersensitive to any of the ingredients. Take care not to slip. Avoid contact with eyes; if this occurs rinse immediately with water. **Undesirable effects:** None known. **Package quantities:** 500ml bottle. **Basic NHS cost:** 500ml £7.50. **Legal category:** GSL. **Product licence number:** PL 00327/0110. **Product licence holder:** Crookes Healthcare Ltd, Nottingham NG2 3AA. **Date of preparation:** May 2002.

CROOKES HEALTHCARE

CHC3K02-22a

ONLINE

P2U gives online access to PMRs

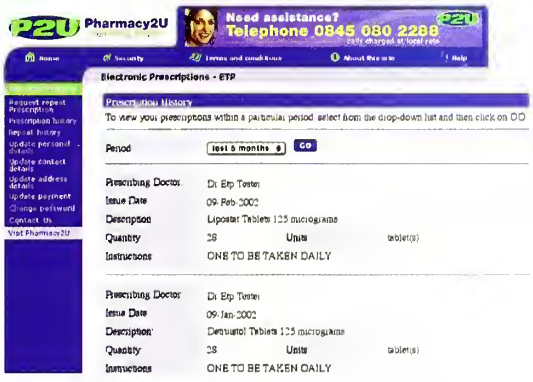
Pharmacy2U is offering patients online access to their medication records as part of its electronic transfer of prescription pilot.

Patients taking part in the P2U-run ETP pilot underway in South East England, can log on to a secure website, *www.pharmacy2u.co.uk/eprescriptions*, where they can view their prescription history, request repeat prescriptions and check their current status.

P2U said the number of people recruited for the pilot was "in the early thousands" and stressed that any messages it exchanged with the GP's surgery via the internet were highly encrypted and digitally signed.

However, P2U's conduct during the early stages of the pilot has been criticised. The company is accused of exceeding its pilot area, initially understood to be Stockport and London, and driving business away from competitors.

Concerns were raised over the inclusion of two East Grinstead surgeries in the pilot, both of which have practice pharmacies.



P2U's website offers patients the chance to view their medication history as well as order prescriptions

Brochures for the pilot, on display in GPs' surgeries, clearly state that the next time the GP issues a prescription "it will be sent automatically to P2U and delivered to your home or place of work".

Among the key benefits listed are the nullified risk of losing a prescription and the option to be reminded when a repeat prescription becomes due.

"We think that all the consortia should be subject to the same rules and conditions as part of the pilot. It is also important that patient choice of pharmacy is explicitly maintained," said Digby Emson, Boots' The Chemists superintendent pharmacist.

But P2U insisted that East Grinstead had been included in the original submission for the pilot, a fact confirmed by the Department of Health.

"Pharmacy2U defined two clusters in its original proposal. Within the details of the clusters there were two East Grinstead practices and one practice listed in Northampton. Additionally, further practices are based in and around London," said the DoH.

But Ian Shepherd, the Royal Pharmaceutical Society's head of information technology, said other sites were rumoured to be targeted by P2U. Confirming that he had been approached by several superintendent pharmacists about this matter, Mr Shepherd said: "This is supposed to be a pilot and you cannot constantly move the goalposts."

He praised the other two consortia, Flexiscript and TransScript, for their openness.

Daniel Lee, managing director of P2U, rejected the criticisms and insisted that the company had gone through the proper channels at every stage.

"It's not about geographical size, it's about improving patient services," Mr Lee argued, adding that some of the other pharmacy retailers were simply trying to protect their interests.

RETAILING

Pharmacy provides key to Tesco's success

Pharmacy services and an expanded complementary medicines portfolio are said to have played a "pivotal" part in the 11 per cent increase in Tesco's trading results for the 12 weeks to May 18.

The grocery group has also developed a continuing professional development portfolio for its pharmacists and is in the process of rolling out the Nutri Centre@Tesco concept in 200 stores.

This represents four times the original number announced when the supermarket giant acquired a majority stake in the natural remedies specialist (*C&D August 11 2001, p30*). The roll-out means that Nutri Centre@Tesco branded shelves are present in virtually all Tesco stores with an in-store pharmacy (213).

Tesco pharmacists have undertaken complementary medicines training and Nutri Centre is providing them with information through a series of newsletters.

INDUSTRY

Price fixers facing charges

Law firm Eversheds has warned that directors of firms which break competition law could face prison sentences.

New laws will be introduced by the autumn containing hard-line measures against price fixing and firms colluding to share a market.

Many companies, it said, may break the law without realising it. "It can be as simple as talking to a competitor in an informal, out-of-office environment where your guard is down and sensitive information can be inadvertently exchanged."

Eversheds advises firms to assess and manage the potential risks by investing in competition law compliance programmes.

MULTIPLES

Gehe completes Unicare deal

Gehe AG has completed the acquisition of Unicare, the 30-strong Irish pharmacy chain, after the two companies reached an out-of-court settlement.

A deal had first been agreed in October 2001. But following the deregulation of the Irish pharmacy market Gehe said it was no longer in a position to complete the acquisition, which prompted Unicare into taking legal action *(C&D March 9, p13)*.

While the actual price of the deal remains confidential, it is believed to be close to €110 million (£71.3m), or 1.6 times Unicare's turnover. Unicare would only confirm that it is "five per cent different" from the price originally agreed in October 2001.

Gehe is also understood to take on debt of €11m (£7.1m) and all legal costs.

Gehe said it was delighted to have acquired the business, which it had "always regarded as excellent businesses, staffed by excellent people and we are excited at the opportunities that the development of these pharmacies present to us.

"From our perspective the final agreement represents an excellent basis for delivery of value to our shareholders and also significantly increases our presence in the Irish market," it said.

Unicare's chief executive, Fergus Hoban, defended the company's decision to take legal action. He said the move had been necessary to ensure the transaction would be completed.

"While I'm extremely annoyed that this was required, I'm delighted that it has achieved the desired result for us, which reflects very substantially the agreement into which we entered," Mr Hoban added.

Calling Gehe's behaviour "deeply disappointing", Mr Hoban said it was a shame that a lot of court time, management time and consultancy time had been wasted.

But Mike Ward, Gehe UK's chief executive and member of the main management board responsible for Gehe's European retail businesses, argued that the impact of the changes had to be assessed before the deal could be allowed to go through. He also pointed out that Gehe was already operating retail pharmacies in some deregulated markets.

Mr Ward added that the Lloydspharmacy name would definitely not be adopted across the Irish chain, as Lloydspharmacy's own research had revealed the name brought negative connotations relating to the Lloyds insurance underwriters.

Meanwhile, Unicare appears to be one of two front runners for a universal name for Gehe-owned pharmacies in Ireland, but a final decision has not yet been made.

INDUSTRY

Too close a shave for Pfizer?

Pfizer Inc is considering selling its shaving and sweets businesses as it explores strategic options.

The Schick-Wilkinson Sword shaving business had a turnover of $620 million (£406.7m) last year and includes brands such as Xtreme™III razors and blade refills, Protector, Silk Effects and FX Diamonds. The division also manufactures ceremonial swords.

Adams, the world's second largest provider of confectionary products, owns the Halls, Dentyne and Clorets brands and last year recorded sales of $1.9 billion (£1.25bn).

"Adams and Schick-Wilkinson Sword are successful, growing businesses. Both have outstanding reputations, world-recognised brands and strong positions in their respective industries," said Pfizer chairman and chief executive, Hank McKinnell.

He added, however, that "these businesses are not aligned with Pfizer's strategic focus on pharmaceuticals and healthcare".

Phoenix Medical Supplies' retiring chief executive Sandy Young (left), and Phoenix AG's chief executive, Dr Bernd Scheifele (right), sport a traditional kilt at the company's European Management Forum held at Scone Place in Dunkeld/Scotland (near Perth). They are joined by Alison Strath, the outgoing chairman of the Royal Pharmaceutical Society's Scottish Executive, and Douglas Long, vice-president IMS Health USA

WHOLESALERS

AU raises £342m

Alliance UniChem has raised €530 million (£342m) through two financing initiatives, the proceeds of which will be used to refinance short-term bank debt and reduce local bank debt in Italy.

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MEDICINES

Farillon told to cut vaccine supply

Farillon Healthcare Distribution, a subsidiary of Gehe UK, has been told by the Department of Health to restrict the supply of the single rubella vaccine to private clinics.

Farillon has an exclusive NHS contract to distribute the vaccine in the UK. The DoH sources around 50,000 doses of the childhood vaccine from GlaxoSmithKline, predominantly for use in the NHS.

GSK, which is preparing for the launch of a multiple vaccine, MMR-V, is the only licensed manufacturer for the rubella vaccine in the UK.

However, excess stock has been made available for sale to the private sector. The DoH said that GSK had only a limited stock while demand from private customers had risen substantially.

"This extra demand is compromising the Department's ability to supply the NHS. The Department has limited the amount of surplus NHS stock which can be bought to protect the interests of NHS patients," it said.

But Kathy Durnford from Direct Health 2000 – a private clinic – accused the DoH of digging its heels in to persuade people to use the MMR vaccine. She added that an order for 300 doses had been reduced to 100. "This is a licensed vaccine in the UK and we should be able to get hold of as many doses as we want."

She rejected the DoH's suggestion that private clinics could order vaccine stock from the manufacturers, because she claims that GSK told her it was stopping production of the single vaccine.

GSK confirmed that the product had been discontinued and it was not accepting more orders. It has enough stock left to fulfil its NHS contract until January 2004.

Sanofi-Synthélabo chief executive Jean-François Dehecq rang in a new era as he celebrated the company's listing on the New York Stock Exchange. From left: Gerard le Fur, executive vice-president, scientific affairs; Hanspeter Spek, executive vice-president, international operations; Robert G Britz, president and chief operating officer, New York Stock Exchange; Marie-Helene Laimay, senior vice-president, chief financial officer; Jean-François Dehecq, chief executive and chairman; Jean-Pierre Kerjoun, general counsel, senior vice-president, legal affairs; John Spinnato, general counsel, senior vice-president, legal affairs Sanofi-Synthélabo US

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Comment from the Editor

Too fast, too confusing, and too predetermined. That seems to be the response to the Royal Pharmaceutical Society's plans to modernise its regulatory functions. The unprecedented action by eleven of the Society's past presidents, telling the current Council to reconsider, should be seen as a warning shot to slow down and listen to the members.

The "Presidents XI" is also telling Lambeth to stop comparing itself solely to other professional regulators like the GMC. Has anyone at Lambeth actually asked the Government whether pharmacy has done a bad job at self-regulation (while combining it with professional representation) up until now?

The fear is that the Council for the Regulation of Health Professionals will want to start flexing its muscles early next year, and could impose external regulation. It has yet to be established what it would take to do this. But it is likely that members of the profession would refuse to pay for an external regulator. What would the taxpayer have to say about that?

Instead of potentially becoming the Government's lapdog, the Society needs to ensure that it does not over-interpret the Government's intentions and change so much that it emasculates its professional function.

Of more immediate concern is the apparent lack of membership involvement in the whole process. Possible factors include poor communication from Lambeth, the lack of clarity in the consultation, the daunting implications of such a change, and even the fact that there does not seem to be a plan B. Why should pharmacists feel obliged to respond – it's all done and dusted, isn't it?

Well no, not quite. Time is short, but nothing has been finalised – in public at least. There is still time to make sure your views are heard, whether you send a simple clear letter saying you agree completely with the Society's actions so far, or that you want the Society to consider alternatives, for example the YPG plan (*C&D June 29, p5*).

Has anyone at Lambeth actually asked the Government whether pharmacy has done a bad job at self-regulation up until now?

Yourviews

Current data exclusivity rules must be changed, says Warwick Smith, director of the BGMA

Generics industry at the crossroads

We may be looking at a defining moment for the generics industry. We currently face a number of very serious regulatory issues that could prevent our continuing to make our vital contribution to the NHS. Apart from damage to the industry itself, it could cost the NHS a significant part of the £3 billion we save it each year.

The current review of pricing and reimbursement of generics in the UK is an obvious issue; but the European Commission's 2001 Regulatory Review, particularly data exclusivity, is just as important.

While I generally welcome the European Commission's review it is vitally important that we get this right. The current data exclusivity rules are open to wide interpretation. Their very vagueness has been used by the innovative sector to deny the onset of generic competition. We need to get the rules clear and right.

Half of Europe currently has six years' data exclusivity and the other half 10 years. The

Warwick Smith of the British Generic Manufacturers Association thinks the European Commission's plan will hinder competition

Commission is proposing to "harmonise" at eleven (10+1). The Commission claims that this is necessary to encourage innovation and to be competitive with the USA, where innovation rates are higher.

But the USA has five years' data exclusivity; with the ability to add up to a further three years. It also has a shorter patent term extension provision.

At one of the recent G10 workshops, American academics argued that the lesser market protection afforded to the research-based industry in the USA contributed to their being more innovative and competitive.

They added that generic competition is a major driver of innovation. So by increasing the innovator's market protection, the Commission will simply undermine the competitiveness of Europe's innovative industry further while putting up costs to the NHS.

Add to that the increasing tendency of the innovative sector to withdraw products before patent expiry. It simply results in a shift of prescribing to branded replacement products, with little or no benefit to patients, but at much greater cost to the NHS.

This practice is basically killing the generic market for a product long before it can be launched. We calculate the cost of this to the NHS over 10 years as being £150 million for a small product, and up to £2bn for a blockbuster.

The NHS can't afford this. Trusts are demanding action to prevent the damage it does to their budgets from anticipated savings that don't materialise.

So we will continue to launch products as they come off patent, and make clear that they can be prescribed and are available.

POLITICS

No plans to use patient snoop laws

The Department of Health has no immediate plans to demand patient information from healthcare professionals.

Last week, shadow health spokesman Dr Liam Fox asked under what circumstances the health secretary would exercise his powers to ask for patient records.

Junior health minister David Lammy replied: "I have no plans to demand patient information from healthcare professionals.

"While the Health Service (Control of Patient Information) Regulations 2002 permit me to introduce a requirement for patient information to be disclosed in support of work on cancer or communicable disease surveillance, I will only do so if so advised by the Independent Patient Information Advisory Group.

"In the absence of such a requirement, the regulations are permissive rather than prescriptive, allowing but not requiring information to be disclosed."

The regulations require the Secretary of State to authorise any requests for access to confidential patient information.

SURVEY

Prescriptions up last year

The number of prescription items dispensed last year in England rose 6.4 per cent to 587 million, according to the Department of Health.

The net ingredient cost (NIC) of all prescriptions dispensed – in real terms – has grown 6.9 per cent to £6,117 million since 2000. The average NIC per item was £10.42, an increase of only 0.4 per cent in real terms and only 15 per cent of items were subject to a prescription charge.

The therapeutic categories which attracted the most prescriptions were the cardiovascular system and the central nervous system with 145m and 109m respectively.

For more information:

www.doh.gov.uk/prescription statistics/index.htm

TOPICAL REFLECTIONS

Wholesaler charging is a risky business...

The rumblings of discontent from wholesalers are getting louder as they detect a unanimity of opinion that might allow them to apply differential charging to their pharmacy accounts *(C&D June 29, p8)*. The irony is that the wholesaler discount wars of the 1980s precipitated today's low margins and that UniChem started the process (which still gives me a fleeting smile). But this is serious talk and as Steve Dunn, managing director of AAH Pharmaceuticals says, it should now be openly debated.

The primary beneficiary of competitive trading in pharmaceuticals is the Treasury. Whether that money provides increased resources exclusively to the NHS or not remains debatable. But certainly any change to the cost base of community pharmacies as a result of wholesalers' activities would lead to a claim by the Pharmaceutical Services Negotiating Committee for increased reimbursement for contractors.

At present the NHS reimburses costs on a swings and roundabouts basis and would be reluctant to change a system that is cheap to administer (if unfair). If wholesalers started to charge the actual costs incurred in servicing individual pharmacies, then the global sum should rise, but it is unlikely that this would be accepted. The result would be that those pharmacies with a high wholesaler servicing cost would pay proportionally more for the privilege, and the inequities of the present system might perversely be more fairly addressed.

Many low overhead cost pharmacies lie in areas that are expensive for wholesalers to service.

High cost pharmacies, eg in city centres, not only lose by the averaging system of NHS reimbursement, but also by the cross subsidies wholesalers apply. Change that system to one where low rental pharmacies start to pay proportionate costs of wholesaler supply, and the pendulum might begin to swing the other way.

In the final analysis, competition will ensure that there will be no dramatic change to the delivery charges levied by any of the wholesalers, but service times could be extended and differential charges may be applied to the most expensive pharmacies. Extend that principle to charging for support services however, and wholesalers may suddenly find themselves exposed to an unexpectedly competitive market. If pharmacies are required to pay for support they will be highly demanding of its quality. Suddenly those pretty planograms will undergo hard critical appraisal and, if found wanting, be discarded.

I think wholesalers should charge for their add-on services. But they run the risk of being found wanting in a competitive market and may have to invest even more in development costs before they are able to produce the quality of support systems that their customers will want to buy.

Arrogant words...

"The arrogance of the man" is my reaction to the statement by Sir Tom McKillop, the chief executive of AstraZeneca, that pharmacists who use parallel imports should receive little support from pharmaceutical manufacturers in establishing medicines management services *(C&D June 29, p10)*.

I do not know which world Sir Tom McKillop lives in but it is obviously not the one I inhabit where every pound of profit has to be painfully extracted from an NHS remuneration system that assumes perfection. My paymasters assume that I will buy from the cheapest legal source and the ethics of UK supply are irrelevant. If I buy UK products I am penalised and lose money. If AstraZeneca does not want its products traded around the EC it could universally price to ensure a level market. Alternatively, it could use similar packaging throughout the EC in order that proper continuity of supply can be ensured and then lobby Brussels to achieve a level playing field between member states.

I buy and supply PI products because I have no choice. Instead of threatening me with the withdrawal of schemes I have not requested, Sir Tom McKillop would be better advised to aim his criticism at the Government, where it belongs.

POLICY

Get ahead on SOPs

The Royal Pharmaceutical Society is encouraging pharmacists to start planning standard operating procedures for dispensing, ahead of the 2005 deadline

All pharmacies, even those without dispensary support staff, should implement SOPs.

The procedures should cover all aspects of the dispensing process and comply with professional requirements in the Code of Ethics. The added value of the pharmacist's professional input into assessing the safety of a prescription and in providing advice to patients should be explicit.

SOPs should specify which activities must be carried out by the pharmacist, including the pharmaceutical assessment, and which tasks can be delegated to identified competent support staff. Additional training must be considered for responsibilities that extend beyond core training and competencies.

Under normal circumstances a pharmacist will carry out a pharmaceutical assessment (or professional check) of every prescription and, once it has been assembled, someone else will perform an accuracy check. In many instances, a pharmacist will carry out this check. In others, qualified technicians who have undergone additional training and competence assessment (accredited checking technicians) will check the accuracy of dispensed items assembled by someone else.

The RPSGB's document on SOPs suggests that monitoring all errors, not just those reaching the patient, is a useful way to review

With standard operating procedures in place, everyone involved in the dispensing process will know what should be done, when, where and by whom

procedures and identify training requirements. It is also good practice for SOPs to incorporate an audit trail so the pharmacist can determine who is responsible for each aspect of the process.

Put simply, an SOP should specify in writing what should be done, when, where and by whom. The Society suggests that, as a minimum, SOPs should cover the following areas:

- Prescription handling. Includes checking the patient details and signature, keeping records and endorsement. A separate SOP may be considered for telephoned prescriptions, to ensure they comply with legal requirements.
- Assessment of the prescription for validity, safety and clinical appropriateness. Includes checking suitability according to the patient's age and weight, and the potential for non-concordance and misuse, as well as the usual parameters such as dosage and interactions.
- Making interventions and problem solving. Should include procedures for clarifying details with a prescriber.
- Assembly and labelling of required product. The SOP should ensure that the medicine matches the prescription and is in date. Other requirements include following health, hygiene and safety procedures at all times.
- Accuracy checking procedure. Wherever possible, an accuracy check should be carried out by a second person. The SOP should be clear about which people are competent and authorised to do this. Self-checking is not recommended other than in exceptional circumstances, for example when the pharmacist is the only person working in the dispensary.

Currently there are no training programmes that will enable non-pharmacists to develop competence in self-checking for accuracy.

In community pharmacy it is good practice to have boxes on the label for the initials of the person who has dispensed the prescription and who has performed the professional check. A further box may be needed for the accuracy check.

- Transfer of medicine to the patient. Includes making sure the right person receives the prescription and, if possible, checking that the patient or patient's representative understands the information given.

The SOP should specify when the pharmacist's involvement is necessary. Even if the patient has been taking the medicine a long time, he or she should always be given the chance to ask questions.

There may be exceptional circumstances where it is necessary to work outside an SOP, if, say, a computer breaks down. The judgement of the pharmacist is then paramount. It is good practice to record such instances.

Take account of holidays, sickness, locums and other temporary staff, volume of work and resources available.

Review SOPs regularly. It is good practice for staff to read and sign that they have understood the procedures.

- The guidance is published in full in the July *Medicines, Ethics and Practice* guide, being circulated this week.

For more information:

www.rpsgb.org.uk/pdfs/sops.pdf

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Dr Imogen Savage, lecturer in primary care pharmacy, King's College London, explains the latest thinking on heart failure

The failing heart

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1240), in association with multiple choice questions being published in C&D August 3, provides one hour's continuing education

Objectives

- To understand the causes of heart failure
- To be aware of the signs and symptoms
- To understand how the heart compensates
- To understand how drugs work in heart failure
- To be aware of preferred treatments

Heart failure can be defined as the inability of the heart to meet the body's normal demands for blood. It is not a single disease but a complicated syndrome in which compensatory endocrine and nervous system actions elsewhere in the body can play an important part.

The condition is becoming more common, partly because the population is ageing and because more people are surviving heart attacks. At least one in 100 people aged 55 and one in 10 80-year-olds have some degree of heart failure. Often the prognosis is not good. Depending on severity, annual mortality ranges from 10 to over 50 per cent.

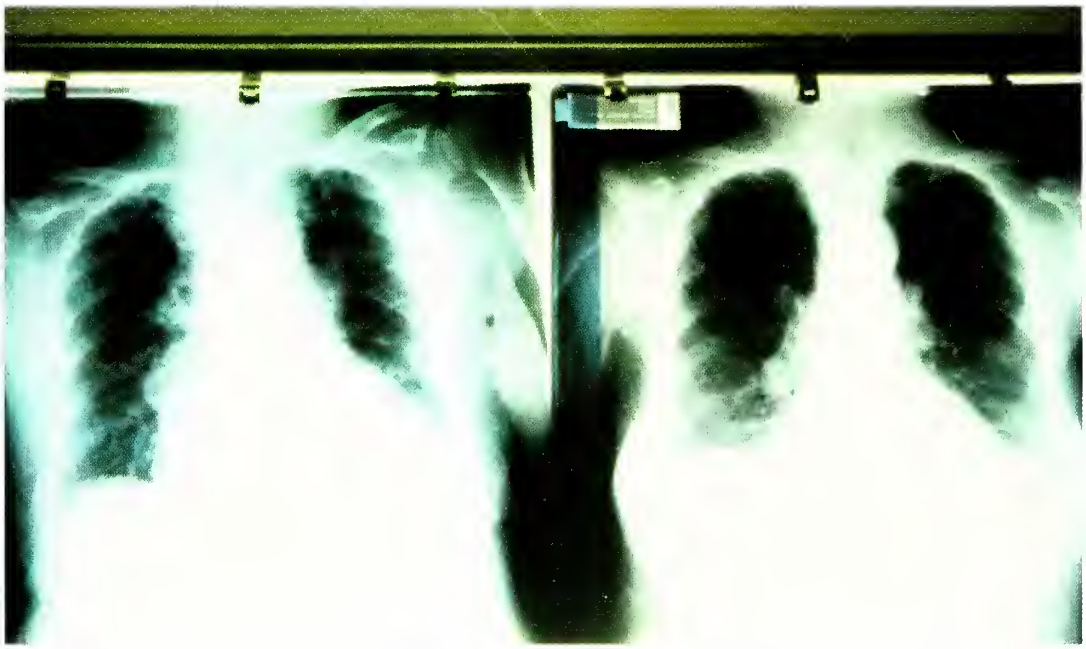
The heart is essentially a pump that pushes blood round a closed circuit of non-rigid tubes. Pump performance is determined by:

- the "priming" with blood (the preload – venous return – on the right side of the heart)
- the intrinsic power or contractility of the heart muscle
- the resistance to flow that has to be overcome to push the blood around the body via the aortic arch.

The larger the volume of blood entering the heart in each cycle, the more stretched the walls become. This stimulates the heart to contract with greater force. In the healthy heart, the greater the initial fill (as in exercise), the more forcible the contraction and the greater is the pressure against which it can expel its contents.

The capacity for this increased contraction is not unlimited and heart failure occurs when these limits are reached.

There are two broad causes of heart failure:



Antonia Reeve/Science Photo Library

X-rays of a patient before (left) and after (right) treatment for heart failure. The heart (white) is greatly enlarged at left, obscuring much of the lung (black) on the right of the X-ray plate. Treatment depends on the cause. Here it has led to a reduction in the heart's size and clearer lungs

- failure of the pump, or the pump overloading with too big a volume on the input (venous) side
- too much pressure on the output (arterial) side.

Overloading causes structural and biochemical changes in heart muscle cells. Hypertension overloads the left (arterial) side of the heart, while increased pressure in the pulmonary circulation overloads the right (venous) side.

Heart valve disease can lead to failure of one or more chambers of the heart, depending on the valve affected.

Ischaemic heart disease is the most common cause of pump failure and it usually affects the left ventricle. Failure can happen suddenly, or a diffuse fibrosis can slowly develop in response to chronic overload.

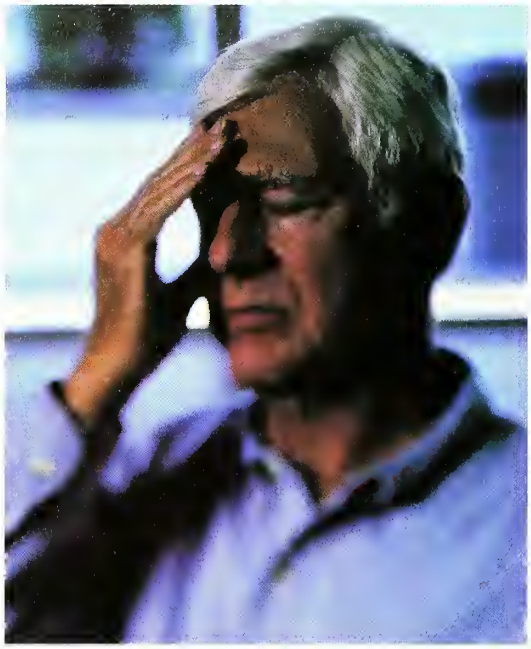
About a third of UK heart failure cases are thought to result from chronic hypertension. Damage also results from alcohol use, infection, inflammation or autoimmune disease.

Most forms of pump failure are the result of the heart muscle's reduced ability to contract (systolic failure). However, heart failure can also happen because the heart muscle fails to relax properly. This is diastolic failure. The condition can be managed, although there are no specific guidelines.

The heart is much more sensitive to the damaging effects of pressure than to volume. Unless the overloading is severe, or very sudden, the body's auto-regulatory systems can normally compensate quite well.

Receptors in the heart and major blood vessels monitor oxygen and pressure levels and feed information up to the brain, which then sends messages back via the sympathetic and parasympathetic nervous system to adjust levels of the appropriate local transmitters (such as noradrenaline) and hormones (such as aldosterone, vasopressin, atrial natriuretic peptide). The

Continued on page 18



Classic symptoms of heart failure include shortness of breath, fatigue and a reduced tolerance of exercise

◀ Continued from page 17

kidney then picks up changes in perfusion and activates the renin-angiotensin system.

The way the body tries to compensate when cardiac output drops is a vital component of chronic heart failure. The healthy resting heart has a good deal of reserve capacity. If output needs to go up, so does the preload, up to a maximum level, when symptoms of congestion appear.

Acute damage, as by an infarct, makes the pump less efficient and output drops. To compensate, the heart enlarges so it can take in more blood, which increases the preload. This allows the patient to function normally at rest, but changes the normal relationship between preload and output. Patients have reduced cardiac reserve and get breathless sooner on exercise.

This is compensated failure and patients can remain in this stage indefinitely if disease progression is halted. However, additional physiological stress, such as an infection, anaemia or sudden fluid overload (as from too much intravenous fluid) can tip the balance and drive them into decompensation.

Non-steroidal anti-inflammatory drug use is an example of this. NSAIDs affect the kidney, reducing renal perfusion, increasing sodium and water retention and increasing blood pressure. Two recent studies have found a link between NSAID use and worsening heart failure in elderly patients.

If cardiac output falls, initially the heart expands to try to maintain perfusion. As the failing heart maintains its demands on its reserve, eventually the heart muscle becomes damaged or "remodelled". Endocrine changes try to maintain cardiac output through effects on blood pressure and kidney function.

The pressure receptors in the heart become less effective. As these receptors normally damp down messages from the sympathetic nervous system, which stimulate the heart to beat faster, there is widespread peripheral vasoconstriction to maintain output via an effect on blood pressure.

Renal blood flow drops, which leads to increased renin secretion and raised levels of angiotensin and aldosterone. The kidney retains sodium and water, which increases the blood volume and the preload on the heart. Initially these compensatory strategies help to maintain cardiac output, but they are maladaptive in that ultimately they may be detrimental. Eventually the cardiac output falls because of increased after-load effects.

Diagnosis

Heart failure can be difficult to diagnose. Classically, patients will have reduced exercise tolerance, increasing shortness of breath, particularly when lying down, and signs of oedema. However, symptoms are often non-specific, as they will depend on whether the main consequences of the failure appear on the venous or the arterial side of the circulation.

Both left and right heart failure reduce tissue perfusion, which can lead to cold hands and feet, pallor, fluid retention, fatigue and exercise intolerance. Metabolic changes and increased sympathetic activity can cause tachycardia and increased respiratory rate.

Fluid accumulation in the lungs produces shortness of breath, coughing, wheezing and central cyanosis. Congestion of the systemic system can produce ankle oedema, abdominal pain, ascites, and peripheral cyanosis.

Key diagnostic signs are acute attacks of shortness of breath at night (paroxysmal noctural dyspnoea) and the need to sleep propped up (orthopnoea). Heart sounds often reveal a displaced apex beat. If the right ventricle is failing, congested jugular veins may appear in the neck- a sign of raised venous pressure. An X-ray may show an enlarged heart.

A normal ECG makes heart failure very unlikely. An echocardiogram will confirm the diagnosis. The ejection fraction (EF) is the ratio of the stroke volume to the end-diastolic volume, and indicates how effective cardiac emptying is. It should be over 50 per cent.

Heart failure is usually graded on symptoms produced by normal physical activity. Grade I is asymptomatic heart failure, only detected on investigation. Grade II patients have symptoms on strenuous exertion; grade III on moderate exertion; and Grade IV have symptoms at rest. Clinical trials often combine these gradings with EF values – the cut-off points used for EF values are not always the same.

How is it treated?

Angiotension converting enzyme inhibitors (ACEIs) are first-line treatments. They have been shown to reduce mortality rates,

Continued on page 20 ▶

About the drugs

Angiotensin converting enzyme inhibitors (ACEIs) inhibit synthesis of the powerful vasoconstrictor angiotensin II and reduce aldosterone release. They should not be used with potassium-sparing diuretics or potassium supplements because of the risk of hyperkalaemia. They act on the arterial and the venous circulation, reducing both preload and after-load on the heart. ACEIs also block the growth-stimulating action of angiotensin on heart muscle.

ACEIs are contra-indicated in aortic or renal artery stenosis, and in patients with a history of angioedema. Renal function should be checked before and during treatment.

Angiotensin receptor antagonists lower blood pressure by blocking the receptors upon which angiotensin II acts. They are not yet licensed for heart failure treatment in the UK.

Loop diuretics inhibit salt reabsorption in the kidney's loop of Henle. They produce greater fluid loss than other diuretics, and provide the most effective symptom relief in left heart failure. Bumetanide is said to be less ototoxic than frusemide, and may be better for people with hearing problems.

Spironolactone is a potassium sparing diuretic that competes with the hormone aldosterone in the distal tubules in the kidney. An increase in aldosterone is one of the maladaptive endocrine mechanisms in chronic heart failure. Spironolactone also has anti-androgen properties.

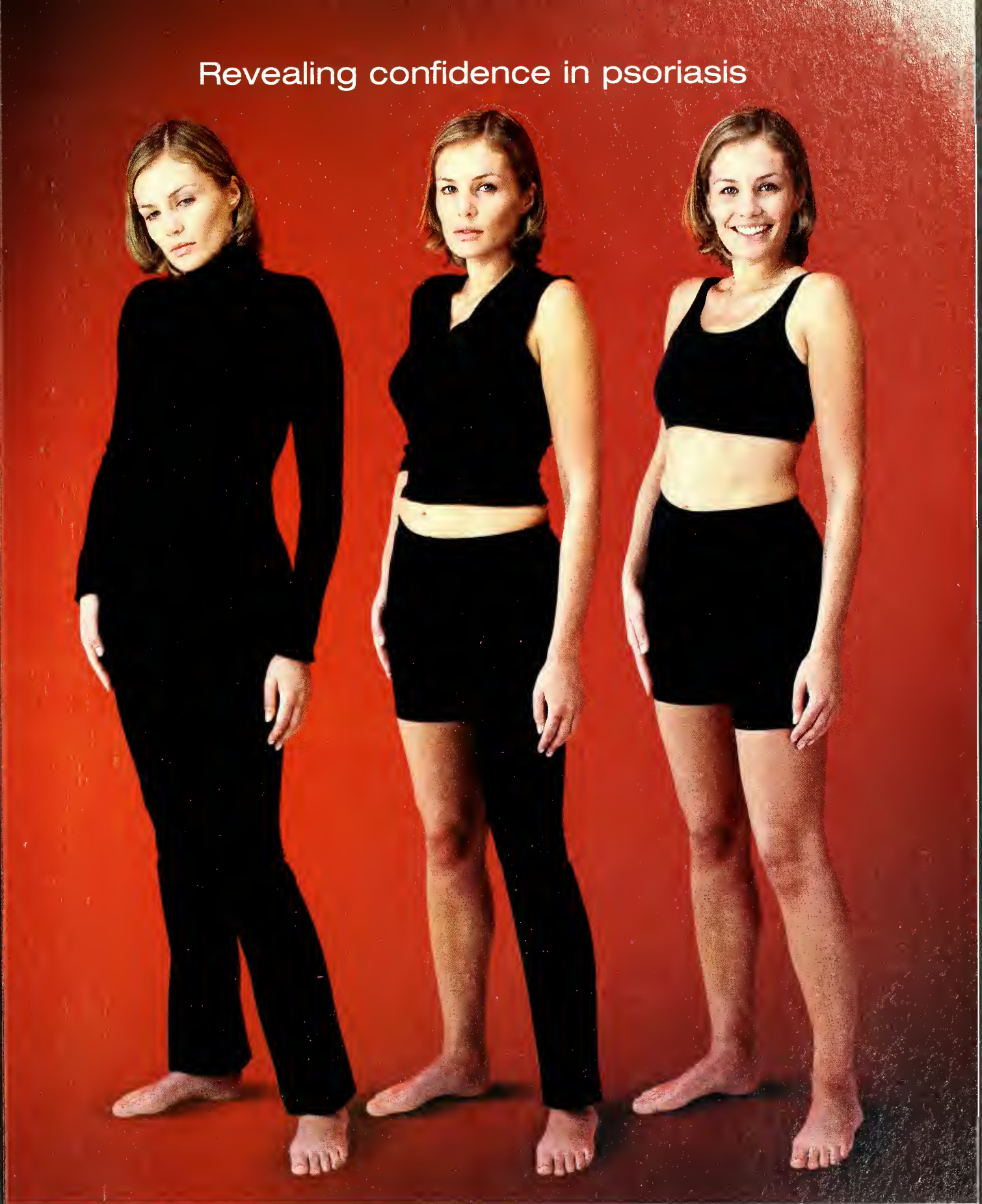
Patients taking spironolactone and ACEIs can develop hyperkalaemia and their potassium levels should be monitored.

Digoxin inhibits the enzyme responsible for exchanging sodium and potassium across cell membranes. This increases sodium levels inside cells, triggering a rise in intracellular calcium and increasing the force of myocardial contraction. Digoxin can also affect the gut, causing nausea, sickness and diarrhoea. These effects are partly caused by a direct action on gut muscle, and partly because of effects on the vagus nerve. Digoxin also slows the heart rate and delays other electrical events in the heart.

Digoxin and potassium compete for the same receptor on the outside of the muscle cell membrane. If potassium levels are low, digoxin effects can be dangerously increased.

Beta-blockers decrease contractility of the heart and can make heart failure worse. However, they also block the unwanted effects of overactive sympathetic stimulation, a maladaptive response that happens in chronic heart failure. Only carvedilol and bisoprolol are licensed in the UK for heart failure.

Revealing confidence in psoriasis



ilkis® Ointment Prescribing Information
resentation: 3 micrograms/g calcitriol ointment. **Indications:** Mild to moderately severe plaque psoriasis *Psoriasis vulgaris).* **Dosage and Administration:** Adults Only - Apply twice daily (morning & evening) before etiring and after washing. There is limited clinical experience available for this dosage regimen of more than weeks. **Contra-indications:** Patients with kidney/liver dysfunction, hypercalcaemia, abnormal calcium netabolism, on systemic treatment of calcium homeostasis, or sensitivity to any ingredients. **Precautions nd Warnings:** Not to be applied to the face. Not recommended for use on more than 35% body surface rea, maximum use 30g per day. Do not cover with occlusive dressing or use substances which stimulate bsorption. Reduce or discontinue use if sensitivity or severe irritation occurs. **Side Effects:** Skin irritation eddening or itching). **Interactions:** Use with caution in patients receiving medications known to increase erum calcium levels, calcium supplements or high doses of vitamin D. Concomitant use of peeling agents, stringents or irritant products may increase irritant effects. **Pregnancy and Lactation:** Not recommended uring pregnancy or lactation unless considered essential by the physician. **PL Number:** PL 10590/0047. **ackage Quantities and Basic NHS Cost.** Tubes of 100g (£24.00) or 30g (£7.20). **Legal Category:** POM. **ull prescribing information is available from the marketing uthorisation holder:** Galderma (UK) Limited, Galderma House, Church ane, Kings Langley, Herts. WD4 8JP, UK. Tel: +44 (0)1923 291033, Fax: 44 (0)1923 291060. **Date of preparation:** March 2002.

GALDERMA DEDICATED TO DERMATOLOGY

SILK/09/0402

Silkis®

calcitriol 3 micrograms/g

New confidence in psoriasis

◀ Continued from page 18

help symptoms and cut hospital admissions in all grades of symptomatic disease. They slow progression and prolong life in people with early disease who have not yet developed symptoms.

The National Service Framework for coronary heart disease recommends that everyone with signs of left ventricular systolic dysfunction should start an ACEI, unless contraindicated (in which case they need specialist referral). If they have clinical signs of fluid overload, they should have a diuretic as well. PRODIGY, the GP prescribing support system, advises GPs to start the diuretic first. Once symptoms are stable, then the ACEI can be introduced carefully. First dose hypotension is a risk, particularly if the patient is frail and elderly, or is taking more than 80mg frusemide a day.

Most ACEIs are licensed for use in heart failure. However PRODIGY advises GPs to use enalapril, lisinopril, ramipril or captopril, as they have the strongest evidence from large clinical trials.

It is not known yet if the newer angiotensin II receptor antagonists (ARAs) such as losartan and valsartan have an advantage over ACEIs. A recent American overview analysis[1] of 17 trials reported that ARAs were not better than ACEIs, either in terms of death rates or hospital admissions. However, using the two drugs together did reduce the odds of being admitted to hospital. The UK view,[2] based on a placebo-controlled study in which valsartan was added to standard therapy, is that valsartan may be beneficial for patients who cannot take ACEIs. But adding the ARA to ACEI and beta-blocker treatment cannot be recommended because in the trial it appeared to reduce survival.

Since the advent of ACEIs, digoxin has been used mainly for controlling heart rate in people with atrial fibrillation. Now the view,[3] based on a review of eleven randomised controlled trials, is that digoxin is a useful add-on treatment in patients in normal sinus rhythm whose symptoms are not controlled with ACEIs and diuretics.

Beta-blockers are a specialist treatment, not recommended for initiation by GPs. Trials in mild to severe heart failure have found that adding some beta-blockers to standard drug therapy can reduce mortality by around a third. Taken for a year, treatment also reduced hospital admission.

Trials have been done only with three UK products: carvedilol, bisoprolol and slow-release metoprolol.

The Copernicus trial looked specifically at severe heart failure, with patients who had symptoms at rest or minimal exertion despite treatment with diuretics and ACEIs or ARAs. This study was stopped early because there was a significant benefit on survival, with a 35 per cent reduction in the risk of death in the carvedilol group.

Beta-blockers can reduce myocardial contractility and make heart failure worse. Ideally treatment should start in hospital, with low starting doses and slow upward titration. Slow heart beat (bradycardia) and worsening heart failure are risks. Breathlessness because of bronchoconstriction (a reason for stopping treatment) needs to be distinguished from worsening heart failure (which could be managed by increasing diuretics).

MeReC (July 2001) concluded that on current evidence, spironolactone, rather than a beta-blocker, is first choice add-on to ACEIs in patients with severe heart failure. Adding 25mg a day reduces frequency of hospitalisation and risk of death.

Pharmacists can help by offering advice and information on avoiding aggravating factors, such as alcohol and a high salt diet

Where does pharmacy fit in?

Pharmacists have an important part to play in the continuing care of people with heart failure, which has one of the highest readmission rates for any common condition. About half of these hospital admissions may be preventable. Possible reasons include uncontrolled symptoms (sub-optimal prescribing) and non-compliance with medication.

Patients and their families can also benefit from practical advice and information about avoiding aggravating factors such as a high salt diet, alcohol and NSAIDs.

The Sheffield heart study, a pilot NPA project in which community pharmacists assessed and monitored medication needs of heart failure patients after discharge from hospital, has already shown that pharmacists can suggest simple solutions to problems affecting patients' lives. Patients in the study felt they were more knowledgeable about their condition and their medicines, and this helped them to feel less anxious and more able to cope. Crucially, patients believed that the community pharmacy-led service could help them to stay independent, in their own homes.

Actionplan

1. Review the indications for cardiac glycosides. Now look at the next 50 prescriptions for digoxin. Estimate how many patients receiving the drug have the conditions for which it is recommended. Do you think it is being prescribed inappropriately? What should you do?

2. In your practice workbook, list the symptoms of heart failure. Against each, note other conditions that can cause that symptom. If a patient presents with any of these symptoms, could you make an informed guess as to the cause? What should you do if the patient has not been diagnosed as having "mild heart failure" but you feel this may be the problem? Do you consider this outside your remit?

3. Do you dispense potassium supplements now? If not, why? If so, why? Why is this significant in the context of this article?

4. Do you dispense NSAIDs to patients with heart failure? It might be worthwhile to record in your practice workbook the next 20 scripts calling for an NSAID for patients whose PMRs suggest they have heart failure. Assess the problem and, if you are concerned, discuss it with the prescriber.

5. Find out as much as you can about the NPA Sheffield study. Can you implement any of that trial to the benefit of your heart?

Further reading

Heart physiology was covered in C&D Pharmacy Update: July 7, 2001, ppI-IV. The role of vasoactive substances was outlined in C&D: August 18, 2001, pII.

References

1. Jong P et al. Journal of the American College of cardiology 2002; 39(3):463-70.
2. MeReC Extra issue; 4 March 2002
3. Digitalis for treatment of congestive heart failure in patients in sinus rhythm. Hood WB et al. The Cochrane Library 2002.

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the August 3 issue, which will cover this week's CPP-accredited modules, together with those in the July 13 and July 27 issues.

The MCQ paper will cover:

● **Heart Failure (1240)** ● **Woundcare (1241)** ● **Body basics: eyes (1242).**

A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wanting to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

C&D in association with GP GENUS PHARMACEUTICALS

Fiery but calming...

Professor *Edzard Ernst* outlines what is known about the possible therapeutic effects of ginger, as well as potential problems

Ginger (*Zingiber officinale*) is a perennial plant native to Asia. It is used abundantly as a spice in Asian cuisine and has been used for millennia for medicinal purposes. In the 16th century, the Spanish introduced ginger to the Caribbean and Central Africa.

Many national pharmacopoeias list ginger for various indications. Its traditional uses centre on the gastrointestinal system, for example nausea, diarrhoea, dyspepsia, flatulence, loss of appetite and stomach ulcers, but many other traditional uses exist, for example in arthritis, respiratory tract infections, cholera, bleeding and as a diuretic.

The rhizome is used for oral medicinal purposes. Topically, the fresh juice has been employed to treat burns.

Pharmacology

Carbohydrates, lipids, pungent phenolic compounds referred to as gingerols, and volatile oils form the main constituents of ginger. The traditional indications are mirrored by an equally wide range of pharmacological actions, which have been shown in in-vitro and animal models.[1] The best-researched activity is probably the antiemetic action, which has been confirmed in animal and human preclinical studies. Other pharmacological activities include positive inotropic, carminative and cholagogue actions. Furthermore, ginger promotes secretion of saliva and gastric juices, and has antiplatelet, antioxidant, antimicrobial, anti-inflammatory and anti cancer activity.

Evidence of effectiveness

Given this wide range of actions, there is a surprising paucity of clinical trials of ginger. The most extensively studied indications are nausea and vomiting of various aetiologies. A systematic review of all randomised clinical trials included six such studies.[2]

Although the results are not entirely uniform, collectively they suggest that ginger is effective for alleviating seasickness, morning sickness, nausea after chemotherapy, and post-operative nausea. This evidence is corroborated by several studies of healthy volunteers in various test models for nausea and vomiting.

One randomised, double-blind, placebo-controlled crossover study recently suggested that ginger extract (170mg three times a day) is not effective in reducing pain in patients suffering from osteoarthritis of the knee or hip.[3]

A placebo-controlled study tested the effects of ginger powder (4g daily for three months) in patients with coronary heart disease.[4] The results showed no effect on platelet aggregation, fibrinolytic activity or fibrinogen levels. A single high dose (10g ginger powder) did, however, yield a significant reduction in platelet aggregation compared with placebo. The relevance of this acute effect is, however, unclear.

Safety issues

Few adverse effects have been associated with ginger. Heartburn may be a problem, particularly in high doses. In disposed individuals, dermatitis can occur. At very large doses, central nervous depression and cardiac arrhythmias may develop.

Mainly because of theoretical considerations, individuals with gallstones, bleeding conditions, diabetes, heart conditions or high blood pressure should use ginger only with caution.

Whether or not ginger is safe in pregnancy is controversial. On the one hand, it has been shown effective for morning sickness,[2] on the other hand there is some concern that gingerol may be mutagenic under certain conditions. Furthermore, ginger is reputed to be an abortifacient. It may therefore be wise not to recommend ginger for pregnant women until positive safety data are available.

Because of its antiplatelet effects, ginger could prolong bleeding time in patients taking anticoagulants. Finally, ginger could potentiate the actions of cardiac and antidiabetic drugs.

Dosage

A dosage of 0.75g to 4g three times daily of powdered rhizome has been used in most clinical trials.

Generally speaking, ginger extracts are safe. They are of proven efficacy for nausea and vomiting of various aetiologies. Therapeutic potential exists for a wide range of other indications but further research is required.

Powdered ginger may be therapeutic, but more research is needed into potential side effects

References

1. Ernst E, Pittler MH, Stevinson C, White AR, Eisenberg D. The desktop guide to complementary and alternative medicine. Edinburgh; Mosby. 2001.

2. Ernst E, Pittler MH. Efficacy of ginger for nausea and vomiting: a systematic review of randomised clinical trials. Br J Anaesth 2000;84:367-71.

3. Bliddal H, Rosetzsky A, Schlichting P et al. A randomised, placebo-controlled, cross-over study of ginger extracts and ibuprofen in osteoarthritis. Osteoarthritis and Cartilage 2000;8:9-12.

4. Bordia A. Effects of ginger and fenugreek on blood lipids, blood sugar, and platelet aggregation in patients with coronary artery disease. Prost Leukot Ess Fat Acids 1997;56:379-84.

Professor Ernst, MD, PhD, FRCP (Edin), is at the Department of Complementary Medicine, University of Exeter

Scriptlines

Aprovel approved

Sanofi Synthelabo's angiotensin II receptor antagonist, Aprovel (irbesartan), is the first in its class to gain approval for the treatment of renal disease in hypertensive patients with Type 2 diabetes.

Of the estimated 1.4 million Type 2 diabetics in the UK, 80 per cent will suffer from hypertension and 25 per cent will develop diabetic renal disease.

However, if treated early, progressive renal disease can be halted or even reversed, in hypertensive Type 2 diabetics.

For more information:

Sanofi Synthelabo
Tel: 01483 505515.

Bigger Dovonex

Leo Pharmaceuticals will launch a 240g pack size of Dovonex (calcipotriol 50mcg per gram) cream next week.

Price: £54.64

Pack size: 240g
Pip code: 288-6943
Leo
Tel: 01844 347333.

Frontshop

Nestlé looks forward to a new arrival

Nestlé is to launch a hypo-allergenic infant formula into independent pharmacies in the UK in early August.

Nan HA is the first infant formula to be marketed through pharmacies by Nestlé in this country. The only other Nestlé baby milk available in the UK is a pre-term formula in hospitals.

Nan HA1 infant formula (suitable from birth) and Nan HA2 infant formula, which is suitable from six months, are formulated for healthy infants who have a family history of allergy.

The baby milks are not suitable for the treatment of cows' milk protein intolerance.

Nan HA is already sold in other European markets and a Nestlé spokesperson says the company has been supplying the product directly to mothers in the UK, who have specifically requested it after buying the milk in other countries.

Price: £4.69

Pack size: 400g
Pip code: Nan HA1 287-0129, Nan HA2 287-0137
Nestlé UK Ltd
Tel: 020 8686 3333.

Herbal help for women

Peter Black Healthcare is adding five herbal supplements to the Gerard House herbal range.

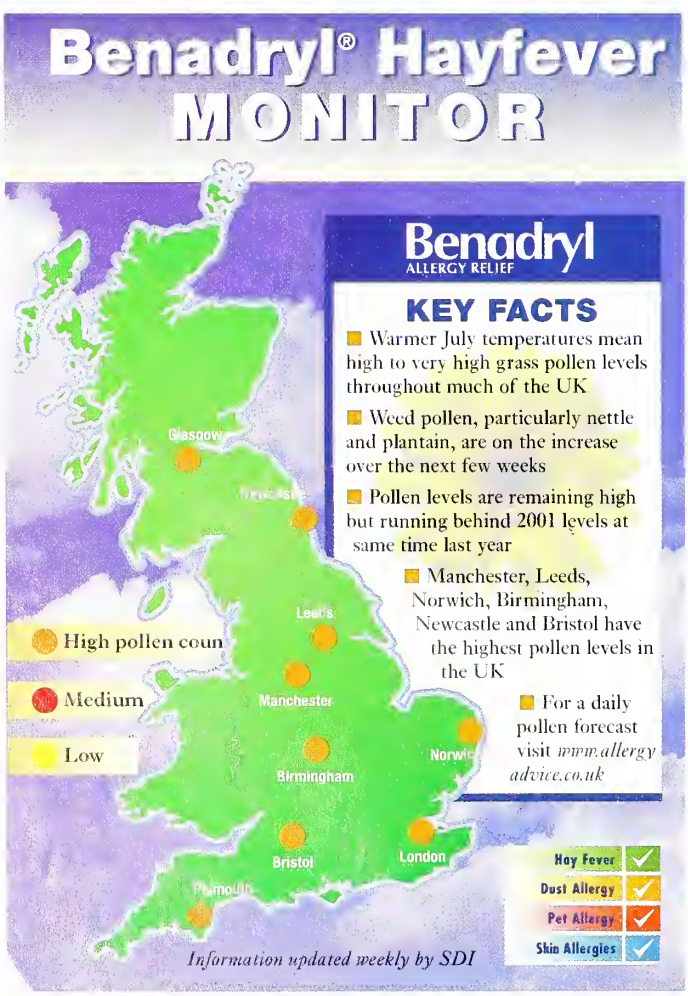
Agnacast contains vitex agnus castus, shown to help establish normal hormone balance.

Raspberry Leaf is traditionally used in pregnancy. Slimmers Aid contains kelp – a herbal remedy used for the treatment of obesity.

Devil's Claw has anti-inflammatory and analgesic actions, so may help arthritis, while Hawthorn has a high bioflavonoid content.

Price: Slimmers Aid £2.99, Hawthorn £3.39, Agnacast £3.99, Devils Claw and Raspberry Leaf £4.49

Pack size: 90 tablets except Slimmers Aid (60)
Peter Black Healthcare Ltd
Tel: 01283 228300.



Pack up your troubles...

TCS Biosciences has developed a compact malaria test kit for travellers.

The Rapimal Malaria Kit is a quick test for the identification of *P falciparum* malaria which can be life threatening without rapid diagnosis and treatment.

The simple cassette format is designed to give a clear positive or negative result in 15 minutes.

Presented in a plastic box, the kit weighs 150 grams, making it suitable for those travelling light.

A rehdration utensil set for travellers is new in the Travelproof range from NoMad Medical.

The set comprises a 200ml stainless steel cup, a spoon and oral rehydration measuring scoop. The cup is exactly the right size to create an electrolyte solution using the scoop.

The scoop is also available on its own.

Price: Rapimal £30, Cup, spoon & scoop set £9.00, Scoop £2.50

NoMad Medical Ltd
Tel: 020 8365 8698.

Spray it with flowers

Agropharm is relaunching Prevent insect repellent with a new look designed to highlight the product's natural ingredients.

Prevent contains pyrethrum – a refined extract from African chrysanthemums – and is powered by an ozone-friendly propellant.

The product can either be used on the body or as a spray to control flying and crawling insects. It comes in a pocket-sized canister containing 400 controlled doses.

Price: £4.99

Pip code: 224-2543
Agropharm Ltd
Tel: 01494 816575.

What is the only OTC treatment for mild external ear infections

Mild external ear infections are a common problem with 9% of the population suffering symptoms such as itching, redness and slight discomfort of the ear.[1] EarCalm Spray is the only treatment you can recommend for mild external ear infections; early treatment may help prevent the infections progressing and so help avoid unnecessary GP visits[2,3]. Its active ingredient, acetic acid, is both antibacterial and antifungal.[2,3] And because it's a spray, it's convenient, easy to use and gives better coverage of the ear surfaces,[2,3] compared to drops so aiding patient compliance.[4]

EarCalm SPRAY
acetic acid

EarCalm. A simple solution.

Product Information. Presentation: Non-pressurised pump action aerosol spray containing glacial acetic acid Ph. Eur. 2.0% w/w as a milky, particle free mobile liquid. **Uses:** Treatment of superficial infections of the external auditory canal. **Dosage and Administration:** Adults, children over 12 years and the elderly: One metered dose (60mg, 0.06ml) to be administered directly into each affected ear three times daily (morning, evening and after swimming, showering or bathing). Continue treatment until two days after symptoms have disappeared, no longer than seven days. Discontinue use if there is no clinical improvement after seven days. **Contra-indications, warnings, etc:** Known sensitivity to any of the ingredients. Not recommended in children under 12 years without medical supervision. **Pregnancy/Lactation:** There are no restrictions to the use of the product in pregnancy and lactation. **Special Precautions:** Patients who are known to have a perforated eardrum should only use under medical supervision. If pain occurs during use, or if symptoms worsen or do not improve within 48 hours or if hearing becomes impaired, stop treatment and refer to a GP. **Pharmaceutical Precautions:** Store upright in the carton below 25°C. Shake bottle before use. Before first use, prime the pump by depressing the actuator 6-10 times until a fine spray is obtained. Use within one month of first use. Avoid spraying near eyes. **Legal Category:** P **Basic NHS Cost:** £3.80. R.R.P.: £6.38 **Product Licence Number:** 0036/0072. **Product Licence Holder:** GlaxoSmithKline Consumer Healthcare, 980 Great West Road, Brentford, Middlesex TW8 9GS **Date of Revision:** June 2002. **References:** 1. Prime data. 2. Malik M *et al.* JAM. MED AFF 1975:89-47. 3. Paulose *et al.* J Lar. Otol. 1989:103:30-35 4. Smith RB, Moodie, J. Current Medical Research and Opinion 1990: 12,12-18 EarCalm is a registered trademark of the GlaxoSmithKline group of companies.

gsk GlaxoSmithKline

Frontshop

Relax with Carmen's crystal ball

With stress on the increase, Salton Europe has designed a range of home relaxation products to help provide an escape from the pressures of daily life.

The Carmen Life Crystal Ball Sound and Aroma System (Model 5633) offers a variety of sound and lighting effects with an aromatherapy option to relax or revitalise.

The unit is supplied with two types of aromatherapy beads – Rejuvenating to stimulate and motivate and Relaxing to create a calming and soothing environment. A timer can be set to stop the effects after 15, 30 or 45 minutes.

The Carmen Life Aqua Jet Bath Mat is a bubble jet product which fits into the base of a bath. The mat features 350 warm air jets for an invigorating all-over massage to help relieve tension and soothe sore muscles for total relaxation.

It has three settings – low, medium and high. A timer offers the option of 10, 20 or 30 minute treatments. The mat features a built in aromatherapy dispenser and comes with the same option of aromatherapy beads as the Crystal Ball.

Price: Crystal Ball £29.99, Bath Mat £99.99

Salton Europe Ltd
Tel: 0161 947 3000.

Inbrief

Lustrous lips

Revlon is introducing two finishes for Super Lustrous Lipsticks at the end of July. Velvet Creams and Velvet Chromes offer a choice of satin matte or metallic shimmer finish in six shades, ranging from caramels to plums and berry reds.

Price: £7.29

Revlon International Corporation
Tel: 020 7284 8700.

Durex resource for schools

A Durex initiative has been launched to support teachers in the fight against sexually transmitted infections and teenage pregnancy. The 10-module sex education CD-Rom will be available free to schools and will help highlight the importance of using condoms. Aimed at 14-16-year olds, the resource incorporates lesson plans, role-playing exercises, information on condoms and HIV/AIDS.

For more information:

SSL International plc
Tel: 0161 654 3000.

Zest readers reward top over the counter products

Elastoplast Scar Reduction Patches and Diflucan thrush remedy have won top awards in *Zest* magazine's first Pharmaceutical Awards.

The awards recognise the contribution the pharmaceutical industry has made to the health and wellbeing of women in the UK.

Zest readers voted for the following products via the health and beauty magazine's website:

Best product for women
Winner: Diflucan thrush remedy.
Runners-up: Levonelle 2 OTC morning after pill and Robinson Femme Ease.

Best innovation
Winner: Elastoplast Scar Reduction Patches.
Runner up: Scholl Flight Socks and SCA Hygiene Products for Bodyform Micro Pantyliner.

Best design and packaging
Winner: Boots Alternatives.
Runner-up: Compeed Plasters and Nurofen range.

Best consumer marketing campaign
Winner: Berocca.
Runners up: Zovirax and Daktarin.

Best use of the web
Winner: Johnson & Johnson for *www.jnjmsd.co.uk*
Runner-up: Bayer for *www.canesten.co.uk* and Pharmacia for *www.nicorette.co.uk*

Sample Soothers for free

Adams is supporting Halls Soothers with a major sampling programme throughout this summer, as part of a £5.5 million marketing campaign for the brand.

Four million special blister packs containing Blackcurrant or Peach & Strawberry varieties will be distributed throughout Great Britain and Ireland.

For more information:

Adams UK
Tel: 02380 620500.

TV next week

Anadin Extra: All areas
AquaBan: GMTV
Benadryl Allergy Relief: B, G, Y, A,HTV, W, M, LWT, TT
Calypso Dry Oil Spray: Sat
Daktarin Gold: C4, ITV, Sat
Durex: C4, C5, Sat
Femfresh: C4, Sat
Hedex: Sat
Lucozade Energy: All areas except U, CTV, GMTV
Macleans: All areas except U, CTV
Malibu: B, G, Y, TT, GMTV, Sat
Movelat Relief: C5
Nivea Sun Children's UV Sprays: All areas
OdorEaters: All areas
Oxy: All areas except U, CTV, GMTV
Pepcidtwo: All areas except CTV, W, GMTV TSW
Piriton: All areas except U, CTV
Scholl Health & Beauty for Feet: All areas except U, A, HTV, CTV, W, M
Senokot: All areas
PharmaSite for next week: Dulco-lax – Window, **Dulco-lax** – In-store, **Canesten-Hydrocortisone** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Back on TV

You're the one that I want

That's what arthritis sufferers will be singing about Pepcidtwo when they see our new TV advertising campaign for the forthcoming summer season.

Unlike other heartburn & acid indigestion treatments, Pepcidtwo contains an antacid and an acid balancer, which means that it acts fast, getting to work in two minutes and lasts, balancing acid for up to 12 hours, for all day or all night relief. And what's more it does all this with just ONE tablet.

This will be music to the ears of 4 million sufferers*, so make sure Pepcidtwo is the ONE you stock & get ready to cash-in on those extra sales.

Pepcidtwo®.
One hit wonder...made to last.

Goes to work within 2 minutes

Balances acid for 12 hours

PEPCIDTWO ESSENTIAL INFORMATION **Product name:** PEPCIDTWO, chewable tablet. **Presentation:** Rose coloured, round, flat chewable tablet containing famotidine 10mg, magnesium hydroxide 165mg and calcium carbonate 800mg. **Uses:** Short-term symptomatic relief of heartburn, acid indigestion or excess acid symptoms. **Dosage and Administration:** adults and adolescents over 16 years old: chew one tablet thoroughly when symptoms occur. No more than 2 tablets to be taken in 24 hours. The maximum continuous treatment period is 6 days. Patients should not purchase a second pack without the advice of a pharmacist or doctor. **Contraindications:** Hypersensitivity to the active substances or any of the excipients. Medical advice should be sought in case of moderate or severe renal failure, severe hepatic impairment, patients with any other illness or taking other medications, middle aged or older patients with digestive troubles occurring for the first time or if these symptoms have recently changed, patients with unintended weight loss associated with dyspeptic symptoms. **Precautions:** Patients should seek medical advice in case of: difficulty swallowing or persistent abdominal discomfort or taking non-steroidal anti-inflammatory drugs, especially the elderly. As Pepcidtwo contains sucrose and lactose, patients with fructose intolerance, glucose-galactose malabsorption syndrome, sucrase-isomaltase deficiency, lactase insufficiency or galactosaemia should not take this medicine. **Side Effects:** headache, nausea, diarrhoea, dizziness, nervousness, flatulence, eructation, dry mouth, thirst, paraethesia, abdominal distension, abdominal pain and taste perversion. **Legal category:** GSL, **PL number** PL13249/0029. **PL Holder:** Johnson & Johnson MSD Consumer Pharmaceuticals, High Wycombe, HP10 9UF. **Packaging quantities, Price:** 6 Tablets, £2.25, 12 tablets, £3.85. Date of preparation: May 2001. *Ipsos RSL Consumer Omnibus Surrey amongst 1,930 adults April 2001.

Johnson & Johnson • MSD
CONSUMER PHARMACEUTICALS

Stand up and be counted

Georgina Craig, the NPA's head of NHS service development, summarises changes in PCT governance arrangements and the implications for community pharmacy

The NPA is keen for more pharmacists to be appointed to PCT executive comittees. This should become easier as governance arrangements are made more flexible

In April 2002, primary care trusts took over from health authorities and became the main focus for primary care planning and service development.

The National Pharmaceutical Association and other pharmacy bodies have long been advocating the need to form links with PCTs and, where possible, for pharmacists to seek appointment to their PCT executive committee (PEC) and indeed, support this aim.[1,2,3]

To date, around 70 of the 320 PCTs have a pharmacist on the PEC and the number is increasing weekly.

In March 2002, guidance on PCTs' governance was published.[4] It outlines changes at both PCT board and PEC level and will mean greater flexibility for PCTs determining their governance arrangements.

There will no longer be a "national model" of governance and local PCT boards will be able to approve changes to governance arrangements themselves.

This means that, if PCTs are keen to appoint community pharmacists to their PEC, it will be easy for them to do so. All they will need is PCT board approval.

A new statutory requirement is that all PCTs have a director of public health on the board. It is up to PCTs to decide how to accommodate this additional place, but it is essential that a lay majority is maintained.

There must still be a public health professional on the PEC and, in many cases, the director of public health will also take up this position.

Subject to legislation, a Patients' Forum will be established for every PCT (and NHS trust). The forum will elect one member to serve on the PCT Board. They will go through the same formal selection processes as other members of the board.

Guidance makes it clear that all professional staff working within the PCT must have clear lines of managerial and professional accountability and clear, accessible routes for professional support, training and leadership.

GPs and other family health service contractors (including community pharmacy contractors) should have access to identifiable professional leads.

PEC members have an important role in professional leadership. Up until now, few PCTs have recognised the need to provide professional support, training and leadership for pharmacy contractors – mainly because pharmacy contracts were still held at health authority level.

The need for this support is an additional and strong argument for appointing a community pharmacist to the PEC where applications have not been successful to date.

However, if PEC pharmacists are to take on such a leadership role, they will need to have additional funding.

"GPs and other family health service contractors should have access to identifiable professional leads"

Alternatively, a PCT-employed pharmacist might adopt this role. In these circumstances, he or she must be able to demonstrate they are competent to provide professional leadership to community pharmacists. Arguably, a community pharmacist representative should be involved in the appointment process.

There will be changes in legislation so the maximum membership of the PEC can be increased to 18 people.

Of these, 14 places are available for professionals. PCTs will decide the make-up of the PEC themselves, but no one profession should be in the majority. In addition, any professional member can now be elected to the PEC chair.

The only other stipulation is that there must be at least one medical practitioner and one nurse among the 14. It will not be a requirement for other family health service contractors or health professionals to be represented on the PEC.

However, the professional membership of the PEC must reflect the functions of the PCT, and ensure that all health professionals are fully included in planning processes.

The guidance gives a specific example of

ental services. It states that, if the PCT is a rovider of dental services, it is expected that a entist will sit on the PEC.

Very few PCTs provide dental services, but ome PCTs may interpret this statement to ean they have to appoint a dentist to the EC. This is not the case, as GPs and nurses re the only ones with a place by right.

Experience shows that pharmacists will robably have to argue this point at local level. he key positions within the PEC are outlined n the box (see right).

Given that there are now three additional laces on the PEC and pharmacists are pecifically named as one of the eligible rofessions, there is an excellent chance of harmacists getting appointed.

Indeed, in areas where one is already ppointed, there is nothing to stop a second harmacist standing.

The guidance is a little woolly on the issue f professional majorities. It says no one rofession can be in a majority and GPs are he ones who stand to lose from this since they urrently dominate most PECs.

However, it is unclear whether one rofessional group could be in a majority mong the 14 professional members, just not mong the 18-strong committee.

The NPA believes diversity of professional epresentation would be in the spirit of the uidance, but vested interest at local level may ead to continued GP domination of PECs, at east in the short term.

Even so, many PCTs will be reviewing their governance arrangements as a result of this guidance, so pharmacists need to make representations to PCTs straight away.

Many committees will need to appoint additional members to iron out GP majorities. This, along with the fact that some PEC members will be coming up for re-election shortly, means there will be new opportunities for pharmacists to stand for PECs over the next year or so.

The final issue of importance is that the allowances payable to members of the PEC are to be increased, effective from 1 April 2002.

PCTs, through their remuneration committees, will have flexibility to vary these if necessary to meet local circumstances. But suggested levels of remuneration for executive committee members (on a time commitment of three days per month) are £5,968 (annual fee) and £4,521 (locum payments). Pharmacists should be paid similar fees.

The conditions have never been better for pharmacists to make the case for appointment to the PEC. There will be free places and pharmacists have a strong case to make.

Taking on this role brings both personal and professional rewards. If you can take the time to commit, consider an application.

The NPA has produced a pack to help pharmacists preparing for interview for appointment to PECs.

Who is on the PEC?

Department of Health guidance says the following people should constitute the PEC:

- PCT chief executive
- director of finance
- at least one social services representative nominated by the local authority
- a public health professional, eg consultant in public health medicine, dental public health, or other specialist
- up to 14 healthcare professionals – at least one GP and one nurse – plus allied health professionals, dentists, pharmacists, optometrists, consultants (no single professional group to be in the majority).

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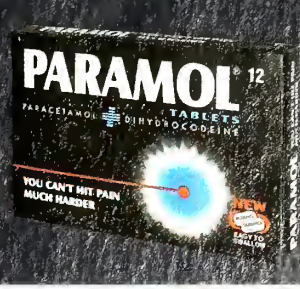


Paramol Prescribing Information: A smooth, white capsule-shaped tablet containing the following active ingredients: Paracetamol 500mg and Dihydrocodeine Tartrate 7.46mg. **Uses:** For the treatment of mild to moderate pain and as an antipyretic. **Dosage and Method of Administration:** To be taken during or after meals. Adults and Children over 12 years: One or two tablets every four to six hours. Do not exceed 8 tablets in any 24 hour period. Children under 12 years: Not recommended. The Elderly: Caution should be exercised when increasing the dose in the elderly. **Contraindications and Warnings: Contraindications:** Hypersensitivity to paracetamol or any other ingredients, respiratory depression, obstructive airways disease. **Warnings:** Paramol Tablets should be given with caution to patients with allergic disorders and should not be given during an attack of asthma. Care is advised in the administration of paracetamol to patients with severe renal or hepatic impairment. If symptoms persist consult your doctor. Keep out of the reach of children. **PL Number:** 11314/0128. **PL Holder:** Seton Products Limited, Tubiton House, Oldham OL1 3HS. **Legal Category:** P. **Pack Sizes and Prices:** 12s – £2.59, 24s – £4.39, 32s – £4.99. **Date of Preparation:** March 2002. *All Outlets – Information Resources £MAT 21st April 2002.

Paramol is the fastest growing top 10 adult oral analgesic brand*

What's the risk?

Continuing our H&S series, Andrea Turner, of Lloydspharmacy, and Phil Robinson, of Gehe UK, outline how to spot potential risks in your pharmacy

Today's health & safety regulations continually use one term: risk assessment. As an employer you are legally obliged to:

- assess the risks to employees and the public from the activities conducted at the branch
- take the necessary steps to eliminate or adequately control the risks
- record these risk assessments.

To carry out a risk assessment you must:

- identify the hazard or the potential of an activity to cause harm, ie a slippery floor, damaged shelving
- assess the risk or likelihood an injury will occur and how severe that injury could be.

There are many different ways of conducting risk assessments, some of which appear extremely detailed and difficult to understand. As with most safety issues, mostly it is a matter of common sense.

"Don't leave that box in the aisle, somebody will fall over it." A simple risk assessment identifies the hazard, the accident potential and severity. The remedy is simple – move the box. Not all risks can be eliminated but they can be controlled.

HAZARD	RISK	SEVERITY
Wet floor from cleaning	Customers or staff could slip	Could be injured from the fall

CONTROL

ELIMINATE	REDUCE
Clean floor out of hours	Place 'wet floor' signs in the area

Fire risk

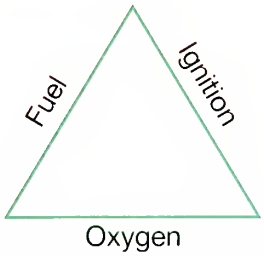
The greatest threat to you, your staff and your business is a major fire. Thankfully, most people are never involved in a fire. Because of this, it is easy to become complacent about fire safety.

Did you know that 85 per cent of businesses that experience a major fire never trade again, or cease trading within one year of re-opening?

- Fire doors are designed to hold back smoke and flames for a period of time – usually 30 minutes, yet these are often propped open, rendering them useless.
- Fire exits are blocked because they are never used.
- Extinguishers are intended to help you escape from a burning building, yet these are often moved because they are in the way.

Sadly, these simple things are overlooked until it is too late: "It will never happen to me." Remember – prevention is better than cure, and, by understanding how a fire works, you can take simple steps to stop one starting.

"The greatest threat to you, your staff and your business is a major fire"



There are three ingredients for a fire – fuel, ignition and oxygen. Take away any one and a fire cannot start.

Fuel

The pharmacy is filled with cardboard, plastic and paper in packaging. All are useful fuels for a fire, so cleaning up rubbish and bringing in bins will prevent a fire from spreading.

Many pharmacies are victims of arson attacks, and one of the prime target areas is the rubbish bin. A steel container will contain a fire better than a plastic one. Using a chain and padlock on the bin lid at night will reduce the risk of the contents being set on fire.

In addition to the normal risks present in a retail outlet, a pharmacy can stock a number of highly flammable substances, which should be stored in the correct containers away from heat sources or direct sunlight.

Many pharmacies stock oxygen cylinders and, although not flammable in themselves, in a serious fire these pressurised containers can become "torpedoes", causing greater damage to the premises. Store cylinders chained and upright, away from heat and direct sunlight, and keep corrosive substances in another part of the stockroom.

Ignition

If smoking is allowed, it should be in a dedicated area, with ashtrays that are emptied regularly. Also, goods should be kept away from radiators and boilers.

Faulty electrical equipment is probably the greatest cause of fires or equipment overheating. All "plug in" appliances must by law be checked regularly by an electrician.

Fire precautions

If a fire starts, it is too late to check whether all the precautions are in place. On a regular basis, you should:

- make sure exits are clearly visible and unblocked. All exits must show the running man/woman pictogram
- ensure fire exits can be opened easily from the inside. Although these exits are a security problem, you cannot have multiple locks and bolts. Lock companies have overcome this by designing a bolt that has multiple locking points, making it difficult to break in. They are opened by pressing a large central pad
- conduct fire evacuation drills twice a year. These can be done out of hours, but the only way you will know whether they work is if customers are present. Ensure that you have the correct fire extinguishers, which should be inspected annually. There are different types of extinguisher for different uses.

A change in the law means that all new extinguishers will be red with a colour-coded label showing the contents.

Extinguishers help you, your staff and customers to escape a fire, and are the equivalent of a plaster on a cut. If you have a major fire, leave it to the professionals, do not attempt any heroics. Appoint a member of staff to call the emergency service and ensure that everybody leaves the building.

This series is based on a Lloydspharmacy health & safety training programme

Types of fire extinguishers

Red	Water	Wood, textiles, packaging
Black	CO_2	Electrical equipment
Blue	Powder	Liquids
Cream	Foam	Liquids

Paramol Tablets

Just as strong – now easier to swallow

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Zest for Life winner

Alternative treatments, such as reiki and Indian head massage, have helped Bellevue Pharmacy win a national service award,reports Gary Paragpuri

The *Zest* for Life Independent Pharmacy of the Year

Jacques Gholam, proprietor of Bellevue Pharmacy in London, says he was "bemused" to discover his pharmacy had won the *Zest* for Life Indepcndent Pharmacy of the Year award.

"I have absolutely no idea who nominated me, but it's a pleasure to win. We have been featured in the local newspapers and customers have complimented and congratulated me. The recognition is enjoyable," he says.

The awards, now in their fourth year, recognise the people, products and services that make a difference to the wellbeing of young women in the UK.

The incorporation of a private consulting area in Bellevue Pharmacy, along with a dedicated treatment room offering alternative treatments such as reiki, Indian head massage, reflexology and holistic massage, were singled out by the *Zest* award judges as reasons why the pharmacy stood out from other entries.

Mr Gholam's family bought the business in 1984 and it was run as part of a chain of six pharmacies. He took over its management in 1991 and bought it six years later.

"The shop was refitted in 1984 and was modern for its time," says Mr Gholam. "But it was much smaller than it is now, using only about half the available space. The dispensary was a small cubbyhole and I couldn't really see out into the shop."

Following a rent increase at the beginning of last year, Mr Gholam felt he had to increase footfall and maximise his turnover. The pharmacy is an agent for Clarins and Lancôme, and both were urging Mr Gholam to upgrade the pharmacy's image.

These factors, coupled with his vision of a more holistic approach to health prevention, led Mr Gholam to decide on a refit.

His plans for the pharmacy included a consultation area and a treatment room where he could offer alternative therapies.

To test the venture's viability he undertook a survey of customer preferences for particular therapies. He received more than 200 replies, with the most popular choices being reflexology, aromatherapy and osteopathy. The least popular was chiropody.

Mr Gholam used the National Pharmaceutical Association's pharmacy planning service and, despite the refit being a "logistical nightmare" – taking eight weeks to complete instead of two – he is delighted with the result.

His old office at the back of the shop has been converted into a treatment room with a separate consultation room. The latter also doubles up as the passport photo studio.

He is particularly pleased with his new "floating" shelving system, which appears to have no visible means of support. "It captured my imagination when I first saw it," he says. The dispensary now has a clear view of the shop and Mr Gholam says he "feels in control".

Betty Tarrant is Bellevue Pharmacy's longest serving staff member, having worked there for 17 years and seen through two major refits.

She says: "The shop now looks wonderful. There is much more space to display the goods and the treatment room has taken off. It draws people in, especially mums. Sometimes the shop is packed with prams, just like Clapham Junction."

Four practitioners provide the alternative therapies at the pharmacy. Treatments include reiki, pranie (re-aligning your energy lines), reflexology, neuro-linguistic programming (de-stressing), aromatherapy and Indian head massage.


Mr Gholam is delighted with his refit

The most popular is reiki, which helps "to remove energy blockades, restore balance and increase a sense of wellbeing. Saturday is the busiest day, with about seven to eight bookings at the moment," says Mr Gholam, and with prices for treatments ranging from £30 to £40 per hour, the investment is beginning to pay dividends.

Claire Bonney, a traditional usui reiki master, provides the £30-an-hour reiki service. She has been practicing and teaching in London for several years, and started at Bellevue just after the refit last November.

So far the services have only been advertised by word of mouth and an "A-board" outside the shop but Jacques is planning to advertise in local newspapers.

Following the refit, turnover is rising and Mr Gholam says he is looking for a 20 to 25 per cent increase.

Despite the pharmacy not being close to any GP surgeries,Mr Gholam says prescription numbers have increased slightly since the refit. He believes people are being lured in by the alternative treatments on offer.

For the future he is hoping to offer osteoporosis screening and a blood pressure monitoring service. He has also given some thought to local pharmaceutical services.

But he believes the June deadline came too soon; November is a more realistic possibility.

"With prices for treatments ranging from £30-£40, the investment is paying off"

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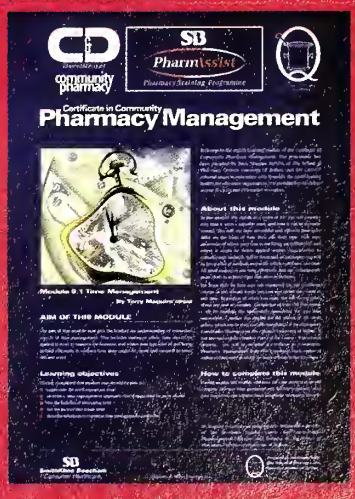

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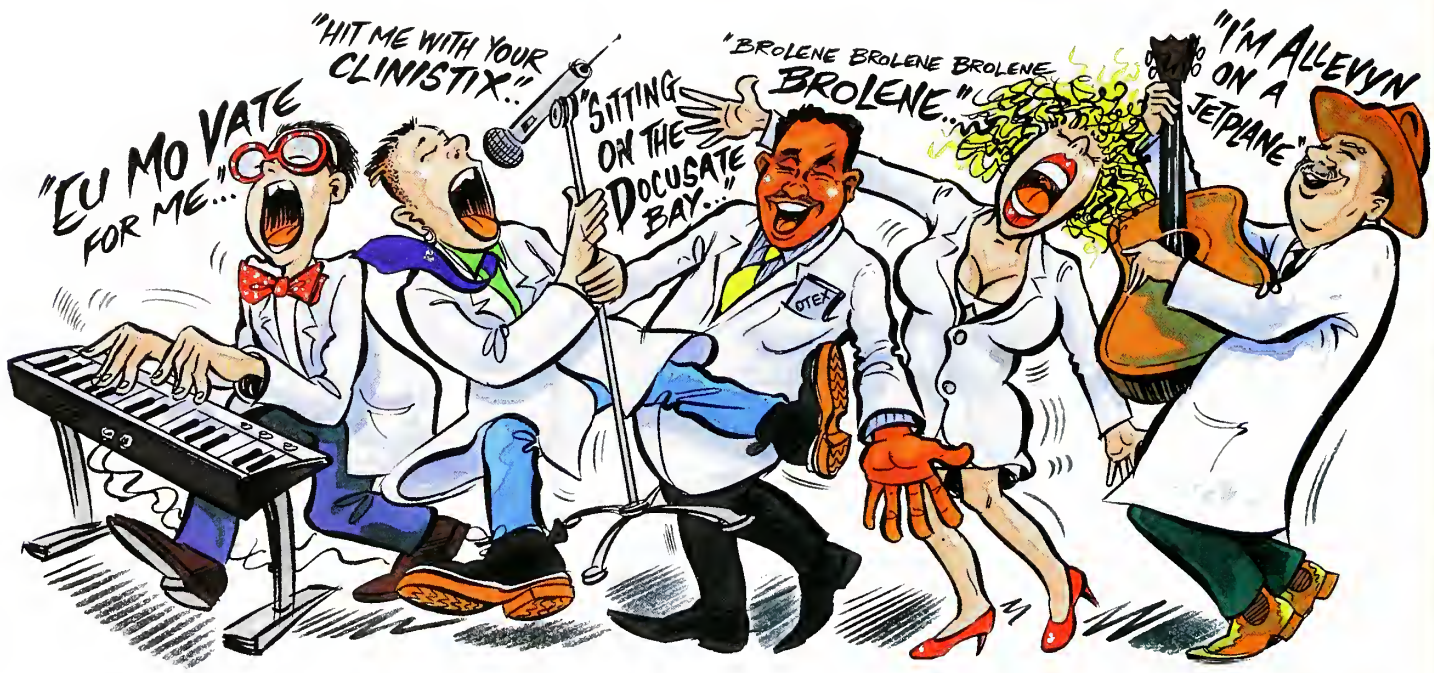
Don't know much about chemistry...

Following a mention on Radio 4's *I'm Sorry I Haven't a Clue* we asked you for songs that might appear in the Pharmacist's Song Book. Here is a selection...



Don Seed

The first people to respond to our call were the staff at the Stapleford branch of Burrows and Close, who did so well in the 'Late arrivals at the pharmacists ball' competition we ran last year.

Their contributions set the tone for the high standard of entries. So, here we go with the Burrows and Close hit parade:

'I'm Allevyn on a jet plane, don't know when I'll be Baclofen'

'Brolene, Brolene, Brolene', a Dolly Parton classic.

'Diamox are forever' by Shirley Bassey,

'Don't cry for me Sertralina'

'Movelat up' by M people

'Sexual Haclan' by Marvin Gaye

'Sitting on the Docusate bay' by Otex Redding (or was it Oxis?)

'Eumovate for me' by Freddie and the Dreamers

'I am saline' by Rod Stewart

'Ferrous across the Mersey' by Gerry and the pacemakers.

From Westside Story, 'Urea, I just met a girl called Urea'

'Brown girl in the pessary ring' by Suleo M.

Following on came a submission from *C&D's* very own Adrienne de Mont, who normally writes for the more sober pages nearer the front of the magazine. Her suggestions include:

'Unchained malady'

'Statin in the shadow of love'

'Griptight, everything is alright'

'Strangers in the Nytol'

"Groan...," she signs off.

Song Martin

Meanwhile, Jon Martin of Proctor's Pharmacy, in Cowley, Oxford, submitted the following. He apologises in advance that not all of them are strictly titles:

'Bad Medicine' by Bon Jela

'I can see Lyclearly now, the lice have gone'

'Pregaday, all my troubles seemed so far away'

'The Keflex' by Duran Duran

'Knowing Mesorb, knowing you, a-ha!'

'D-I-S-C-O' (I don't want any of that generic co-proxamol!)

'The Powergel of Love'.

For those selling reading glasses: 'You ain't seen nothing yet!'

'A C E of Spades', Motorhead

'Hit me with your Clinistix! Hit me! Hit me!'

He also dreamt up song lyrics "10 years ago in Uni", to the tune of 'My Girl'. Unfortunately most of his ditty describes the side effects of ergot alkaloids a little too graphically but suffice to say it concludes:

'What can make me feel this way?

Mi-gril.'

Yorkshire view

Moving north, from Robert Fox, Paula Wilson and Dot Glen of the Milcusnic Chemist in Batley, West Yorkshire, come the following suggestions:

'Baby you can drive my Cardura'

'Scholls out for summer'

'My, my, my Viagra'

'Solid as a roc'

'Asilone am I'

'Get your Motrin running'

'Zanadip-ee-de-do-daa'

'Zirtek a chance on me'

'Estrapak up your troubles in your old kit bag'

'Surgical spirit in the sky'

'Twinkle twinkle little Staril'

'Magnapen-ny lane'

'Sitting on the dock of Glucobay'

'Bezalip-stick, powder and paint'

'Electrolade-y Madonna'

'Isotard of being alone'

'K-Y-ing over you'

'Immac the knife'

'The urban Diprobase-man'

'Viscotears on my pillow'

'Relaxit, don't do it'

'Su-su-sulco'

'Dioralyte my fire'

Wholly Trinity

Bill O'Neill of the Trinity Pharmacy, Bishop's Stortford, Hertfordshire says that a few of the staff's favourite tunes "that we like to sing while bashing out the repeat prescriptions" include:

'Hey Mr Tambocor Man'

'Good Vibramycin'

'Eli Lilly the Pink'

'Minulet in G'

'Air on a Estring'

'Liquifilm tears of a Clown'

'AAH freak out'

'Blue Dansac Waltz'

"The Champagne would make us even more musical," he adds.

Nice try Mr Neill, but aren't you needed in the dispensary as a Mrs Trellis has just come in with her 43 items she wants yesterday?

...and the winner is

Well done and thank you to all the above, but congratulations to the Burrows and Close team for their winning entry and the champagne will be on its way.

Just in case their employers are a bit anxious about the staff's commitment, the team told *C&D*: "We'd like our bosses at Burrows and Close to know that the girls at Stapleford do work occasionally but we find it very hard to resist your competitions!"

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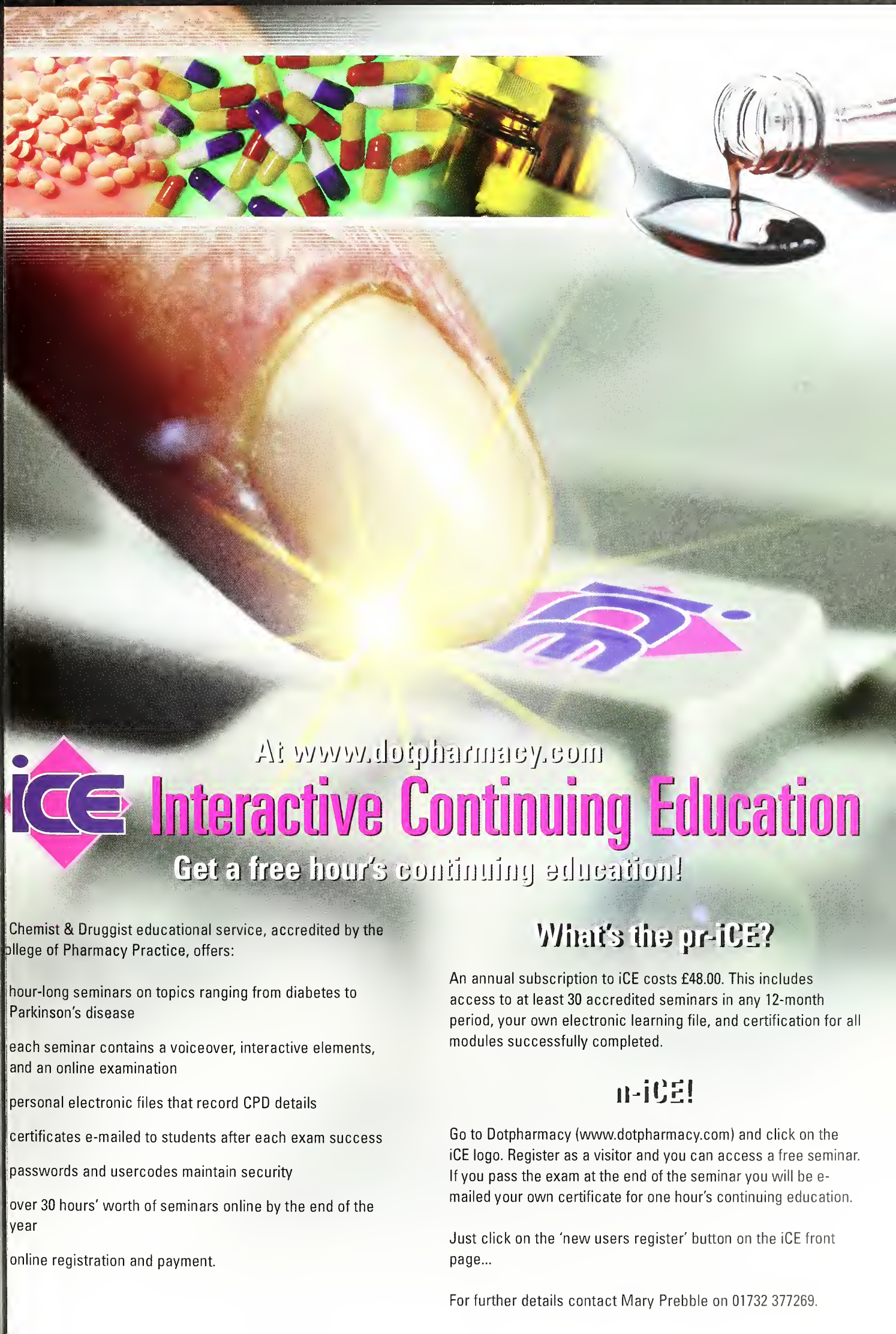

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As Seen On TV

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- Uniquely formulated, clinically proven treatment
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- Designed to inhibit spread of the verruca/wart infection
- No plasters necessary ■ Simple, once-daily application

PHARMACY ONLY

Extra strength treatment for verrucas and warts

- Uniquely formulated extra strength treatment
- Dries to form a water-resistant, protective barrier
- Designed to inhibit spread of the verruca/wart infection
- No plasters necessary ■ Simple, once-daily application

salicylic acid, lactic acid

salicylic acid

NO NEED FOR PLASTERS

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